



MEDICAL STAFF BYLAWS

July 19, 2011

and

RULES AND REGULATIONS

June 21, 2011

**MEDICAL STAFF BYLAWS
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ARTICLE ONE
GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in these Bylaws and related policies and manuals:

1. "ADVANCED ALLIED HEALTH PRACTITIONER" (hereinafter referred to as "Advanced Practitioner") means a licensed or certified practitioner not appointed to the Medical Staff, who has been granted clinical privileges to provide care to patients.
2. "ADVANCED MID-LEVEL PRACTITIONER" means those individuals whose state licensure or certification requires physician supervision and/or collaboration.
3. "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Medical Center to provide patient care services.
4. "BOARD" means the Board of Trustees of the Medical Center which has the overall responsibility for the Medical Center or its designated committee.
5. "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.
6. "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
7. "CLINICAL PSYCHOLOGIST" means that individual who holds a current, valid license to practice clinical psychology or psychology pursuant to the applicable Florida statutes.
8. "DAYS" means calendar days.
9. "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
10. "DEPENDENT ALLIED HEALTH PRACTITIONER" (hereinafter referred to as "Dependent Practitioner") means a licensed or certified health care practitioner, or other practitioner, not appointed to the Medical Staff who is permitted to function under the direction of, or in collaboration with, a supervising physician pursuant to a written scope of practice.
11. "EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff.
12. "INELIGIBLE PERSON" means any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services; and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.
13. "MAJORITY VOTE" means fifty percent plus one (50% + 1) of the individuals present and voting.
14. "MEDICAL CENTER" means Lake City Medical Center.
15. "MEDICAL STAFF" means all physicians, dentists, podiatrists and clinical psychologists who have been appointed to the Medical Staff and granted clinical privileges by the Board.

16. "MEDICAL STAFF LEADER" means any Medical Staff officer, department chief, section coordinator, and committee chairperson.
17. "MEMBER" means any physician, dentist, podiatrist and clinical psychologist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center.
18. "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Medical Center mail, or hand delivery.
19. "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
20. "PATIENT CONTACTS" includes any admission, consultation, procedure, response to in-house emergency call, evaluation, or treatment in any facility operated by the Medical Center or affiliate, including outpatient facilities.
21. "PERFORMANCE IMPROVEMENT" means the continuous evaluation and adaptation of functions and processes of the Medical Center and its facilities to increase the probability of achieving desired outcomes and to better meet the needs of patients and the community.
22. "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s") legally authorized to practice medicine and surgery by the State in which he performs such function or action. [42 U.S.C. §1395X]
23. "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.") legally authorized to practice podiatry by the State in which he performs such function or action.
24. "PROFESSIONAL REVIEW ACTION" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of an appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.
25. "PROFESSIONAL REVIEW ACTIVITY" means a peer review activity of the Medical Center with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have appointment and clinical privileges; (b) to determine the scope or conditions of appointment and clinical privileges; and (c) to change or modify appointment and/or clinical privileges.
26. "PROFESSIONAL REVIEW BODY" means the Board of Trustees or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.
27. "SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt or overnight delivery service providing receipt.
28. "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Dependent Practitioner or an Advanced Mid-Level Practitioner and to

accept full responsibility for the actions of the Dependent Practitioner or Advanced Mid-Level Practitioner while he or she is practicing in the Medical Center.

29. "SUPERVISION" means the supervision of, or collaboration with, an Advanced Mid-Level Practitioner or a Dependent Practitioner and a supervising physician, that does not require the actual presence of the supervising physician, but that does require that the supervising physician be readily available for consultation.
30. "UNASSIGNED PATIENT" means any individual who comes to the Medical Center for care and treatment who does not have an attending physician on staff; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the Medical Center.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Medical Center management, by a Medical Staff member, or by a Medical Staff Committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

1.D. MEDICAL STAFF DUES

- (1) Annual Medical Staff dues shall be as recommended by the Executive Committee and may vary by category.
- (2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.
- (3) Signatories to the Medical Center's Medical Staff account shall be the Chief of Staff, Vice Chief, and Secretary-Treasurer.

ARTICLE TWO
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in these Bylaws are eligible to apply for appointment to one (1) of the following categories:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who:

- (a) have demonstrated a commitment to the Medical Staff and Medical Center through service on Medical Center or Medical Staff committees and active participation in performance/quality improvement functions; and
- (b) are involved in at least 24 patient contacts per two-year appointment term.

2.A.2. Prerogatives:

Active Staff members:

- (a) may vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings;
- (b) may hold office, serve as department chiefs and serve on committees; and
- (c) are entitled to priority scheduling for non-emergency/elective patients for the operating room.

2.A.3. Responsibilities:

Active Staff members must:

- (a) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call, care for unassigned patients and evaluation of members during the provisional period;
- (b) participate in the peer review and performance improvement process;
- (c) accept consultations when requested;
- (d) attend applicable meetings;
- (e) pay application fees and assessments; and
- (f) perform duties as assigned by the Chief of Staff.

2.B. CONSULTING STAFF

2.B.1. Qualifications:

The Consulting Staff shall consist of practitioners of recognized professional ability and expertise who provide a service that is not available on the Active Staff, and who are appointed to the Active Staff at another hospital where they are currently practicing. At the time of initial appointment and at each reappointment time, they must provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges.

2.B.2. Prerogatives and Responsibilities:

Consulting Staff members:

- (a) may treat (but not admit) patients in conjunction with another physician on the Active Staff;
- (b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (without vote);
- (c) may not hold office or serve as department chiefs or committee chairpersons; and
- (d) shall pay application fees and assessments.

2.C. AMBULATORY STAFF

2.C.1. Qualifications:

The Ambulatory Staff category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s). The Ambulatory Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Ambulatory Staff shall be fully credentialed and shall be granted membership based on a recommendation by Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted, Ambulatory Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

2.C.2. Prerogatives:

Members of the Ambulatory Staff may visit their hospitalized patients, and review their patients' medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Ambulatory Staff shall not be eligible to vote or hold office within the Medical Staff organization.

2.C.3. Responsibilities:

Each member of the Ambulatory Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Ambulatory Staff shall establish appropriate referral and coverage arrangements with an Active or Consulting Staff Member for the medical care of his/her patients that require Hospital services.

2.D. EMERITUS STAFF

2.D.1. Qualifications:

The Emeritus Staff shall consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long-standing service to the Medical Center, and have retired from the active practice of medicine.

2.D.2. Prerogatives and Responsibilities:

Emeritus Staff members may:

- (a) not consult, admit or attend to patients;
- (b) attend staff and department meetings when invited to do so (without vote);
- (c) be appointed to committees (without vote);

- (d) not vote, hold office, serve as a department chief; and
- (e) not pay application fees or assessments.

ARTICLE THREE
OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief and Secretary-Treasurer.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. To qualify for the position of Chief of Staff, a member of the Medical Staff must be a doctor of allopathic or osteopathy.¹ They must:

- (1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least one (1) year;
- (2) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (3) not presently be serving as Medical Staff officers, Board Members or department chiefs at any other hospital and shall not so serve during their terms of office;
- (4) be willing to faithfully discharge the duties and responsibilities of the position;
- (5) have demonstrated an ability to work well with others; and
- (6) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Medical Center or any affiliate.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

- (a) act in coordination and cooperation with Medical Center management in matters of mutual concern involving the care of patients in the Medical Center;
- (b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the Chief Executive Officer and the Board;
- (c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee;
- (d) appoint all committee chairpersons and committee members, in consultation with the Executive Committee;
- (e) chair the Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;
- (f) promote adherence to the bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Medical Center;
- (g) recommend Medical Staff representatives to Medical Center committees;
- (h) perform all functions authorized in all applicable policies; and
- (i) have the responsibility for the organization and conduct of the Medical Staff.

3.C.2. Vice Chief:

The Vice Chief shall:

- (a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

¹ LD.01.05.01, §482.22(b)(3)

- (b) serve on the Executive Committee;
- (c) assume all such additional duties as are assigned to him or her by the Chief of Staff or the Executive Committee.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

- (a) be responsible for providing notices as specified in these Bylaws;
- (b) serve on the Executive Committee; and
- (c) be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff fund and report regarding the same to the Medical Staff.

3.D. NOMINATIONS

The Chief of Staff shall appoint a Nominating Committee consisting of three (3) members of the Active Staff for all general and special elections. The Committee shall convene at least 45 days prior to the election and shall submit to the Chief of Staff the names of one (1) or more qualified nominees for each office. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Article Three (3) *Officers*, Section 3.B, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

Candidates receiving a majority of written votes cast shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of one (1) year or until a successor is elected.

3.G. REMOVAL

- (1) Removal of an elected officer or a member of the Executive Committee may be effectuated by a two-thirds vote of the Executive Committee; or by the Board for:
 - (a) failure to comply with applicable policies, bylaws, or rules and regulations;
 - (b) failure to perform the duties of the position held;
 - (c) conduct detrimental to the interests of the Medical Center and/or its Medical Staff; or
 - (d) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee (or the Board) prior to a vote on removal.

3.H. VACANCIES

- (1) A vacancy in the office of Chief of Staff shall be filled by the Vice Chief, who shall serve until the end of the Chief of Staff's unexpired term.
- (2) The new Chief of Staff will select the other vacancies created by his or her elevation. In the event there is a vacancy in another office, the Executive Committee, in its discretion, shall appoint an individual to fill the office for the remainder of the term or until a special election can be held.

ARTICLE FOUR
STAFF DEPARTMENTS

4.A. ORGANIZATION

- (1) The Medical Staff shall be organized into the clinical departments as listed in these Bylaws.
- (2) Subject to the approval of the Board, the Executive Committee may create new clinical departments, eliminate departments, create sections within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

- (1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.
- (2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF CLINICAL DEPARTMENTS

The clinical departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, and (ii) to monitor the practice of all those with clinical privileges in a given department. Each department shall assure emergency call coverage for all patients.

4.D. QUALIFICATIONS OF CLINICAL DEPARTMENT CHIEFS

Each clinical department chief shall:

- (1) be an Active Staff member;
- (2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
- (3) satisfy the eligibility criteria in Article Three (3): *Officers*, Section 3.B.

4.E. APPOINTMENT AND REMOVAL OF CLINICAL DEPARTMENT CHIEFS

- (1) Except as otherwise provided by contract, clinical department chiefs shall be elected by the Medical Staff, subject to Board confirmation. A nominating committee, appointed by the current department chief and the Chief of Staff, shall nominate qualified candidate(s). The election shall be by ballot. Ballots may be returned in person, by mail or by facsimile. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.
- (2) Any clinical department chief may be removed by a two-thirds vote of the department members; or by a two-thirds vote of the Executive Committee subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

- (a) failure to comply with applicable policies, bylaws, or rules and regulations;
 - (b) failure to perform the duties of the position held;
 - (c) conduct detrimental to the interests of the Medical Center and/or its Medical Staff; or
 - (d) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the clinical department or Executive Committee or the Board, as applicable, prior to a vote on such removal.
 - (4) Clinical department chiefs shall serve a term of one (1) year.

4.F. DUTIES OF CLINICAL DEPARTMENT CHIEFS²

Each clinical department chief is accountable for the following:

- (1) all clinically related activities of the department;³
- (2) all administratively related activities of the department, unless otherwise provided for by the Medical Center;⁴
- (3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;⁵
- (4) recommending criteria for clinical privileges that are relevant to the care provided in the department;⁶
- (5) recommending and evaluating requests for clinical privileges for each member of the department;⁷
- (6) assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center;⁸
- (7) the integration of the department or service into the primary functions of the Medical Center;⁹
- (8) the coordination and integration of interdepartmental and intradepartmental services;¹⁰
- (9) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;¹¹
- (10) recommendations for a sufficient number of qualified and competent persons to provide care treatment and services;¹²

² MS.01.01.01, MS.06.01.07, LD.04.01.05

³ MS.01.01.01, MS.06.01.07, LD.04.01.05

⁴ MS.01.01.01, MS.06.01.07, LD.04.01.05

⁵ MS.01.01.01, MS.06.01.07, LD.04.01.05

⁶ MS.01.01.01, MS.06.01.07, LD.04.01.05

⁷ MS.01.01.01, MS.02.01.01, MS.06.01.07, LD.04.01.05, 42 C.F.R. §482.22(c)(6)

⁸ MS.01.01.01, LD.04.03.01, LD.04.03.09

⁹ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁰ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹¹ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹² MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

- (11) determination of the qualifications and competence of department personnel or service personnel who provide patient care, treatment and services;
- (12) continuous assessment and improvement of the quality of care, treatment and services provided;¹³
- (13) maintenance of quality monitoring programs, as appropriate;¹⁴
- (14) the orientation and continuing education of all persons in the department or service;¹⁵
- (15) recommendations for space and other resources needed by the department or service;¹⁶
- (16) performing all functions authorized in these Bylaws; and
- (17) appointing one (1) or more clinical section coordinators as deemed necessary, subject to approval of the Executive Committee.

4.G. CLINICAL SECTIONS

4.G.1. Functions of Clinical Sections:

- (a) Clinical sections may perform any of the following activities:
 - (1) continuing education;
 - (2) discussion of policy;
 - (3) discussion of equipment needs;
 - (4) development of recommendations to the clinical department chief or the Executive Committee;
 - (5) participation in the development of criteria for clinical privileges (when requested by the department chief); and
 - (6) discussion of a specific issue at the special request of a department chief or the Executive Committee.
- (b) No minutes or reports of clinical sections will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, department chief, Credentials Committee, or Executive Committee.
- (c) Clinical sections shall not be required to hold any number of regularly scheduled meetings.

4.G.2. Qualifications and Appointment of Clinical Section Coordinators:

Clinical section coordinators shall meet the same qualifications as department chiefs and shall be appointed and removed by the relevant clinical department chief.

4.G.3. Duties of Clinical Section Coordinators:

The clinical section coordinators shall carry out the duties requested by the clinical department chief. These duties may include:

- (a) review and reporting on applications for initial appointment and clinical privileges, including interviewing applicants;
- (b) review and reporting on applications for reappointment and renewal of clinical privileges;
- (c) evaluation of individuals during the provisional period;
- (d) participation in the development of criteria for clinical privileges;

¹³ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁴ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁵ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁶ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

- (e) review and reporting on the professional performance of individuals practicing within the section; and
- (f) delegation to a vice section coordinator such duties as appropriate, including, but not limited to, the review of applications for appointment, reappointment, or clinical privileges or questions that may arise if the section coordinator has a conflict of interest with the individual under review.

ARTICLE FIVE
MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. EXECUTIVE COMMITTEE

5.A.1. Composition:

- (a) The Executive Committee shall include the officers of the Medical Staff, the Chief of the Department of Medicine, the Chief of the Department of Surgery, one Medical Staff member of a hospital-based clinical section who shall be appointed by the Chief of Staff, and one Active Staff member at large who shall also be appointed by the Chief of Staff.
- (b) The Chief of Staff shall serve as chairperson of the Executive Committee.
- (c) The Chief Executive Officer and Chief Nursing Officer shall be *ex officio* members of the Executive Committee, without vote.

5.A.2. Duties:

The Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The Executive Committee shall be responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Executive Committee meetings). The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws.¹⁷
- (b) recommending directly to the Board on at least the following:
 - (1) the Medical Staff's structure;¹⁸
 - (2) the mechanism used to review credentials and to delineate individual clinical privileges;¹⁹
 - (3) recommendations of individuals for Medical Staff membership;²⁰
 - (4) recommendations for delineated clinical privileges for each eligible individual;²¹
 - (5) participation of the Medical Staff in Medical Center quality assessment, performance improvement, and patient safety activities;²²
 - (6) the mechanism by which Medical Staff membership may be terminated;²³
 - (7) mechanism for fair hearing procedures;²⁴ and

¹⁷ MS.01.01.01

¹⁸ MS.02.01.01

¹⁹ MS.02.01.01

²⁰ MS.02.01.01

²¹ MS.02.01.01

²² MS.05.01.01, MS.05.01.03

²³ MS.02.01.01

²⁴ MS.10.01.01

- (8) reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Medical Center.²⁵
- (c) consulting with administration on quality related aspects of contracts for patient care services;
- (d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate;
- (e) reviewing, at least every three (3) years, the bylaws, policies, rules and regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and
- (f) performing such other functions as are assigned to it by these Bylaws and/or other applicable policies of the Medical Staff and the Medical Center.

5.A.3. Meetings:

The Executive Committee shall meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.B. PERFORMANCE IMPROVEMENT FUNCTIONS

- (1) The performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require Medical Staff leadership or participation. These functions shall be performed by such committees, departments and individuals as may be designated by the Executive Committee in consultation with the Chief Executive Officer. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:
 - (a) medical assessment and treatment of patients;
 - (b) use of medications;
 - (c) use of blood and blood components;
 - (d) use of operative and other procedures;
 - (e) efficiency of clinical practice patterns; and
 - (f) significant departures from established patterns of clinical practice.
- (2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in these Bylaws.

5.C. PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, though are not limited to:

- (1) education of patients and families;
- (2) coordination of care with other practitioners and Medical Center personnel, as relevant to the care of an individual patient; and
- (3) accurate, timely, and legible completion of patients' medical records.

²⁵ 42 C.F.R. §482.12(a)(5); 42 C.F.R. §482.22(b)

5.D. APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS

- (1) All committee chairpersons and members shall be appointed by the Chief of Staff, in consultation with the Executive Committee. Committee chairpersons shall be selected based on the criteria set forth in Article Three (3): *Officers*, Section 3.B of these Bylaws.
- (2) Committee chairpersons and members shall be appointed for initial terms of one (1) year, but may be reappointed for additional terms.
- (3) The Chief of Staff and the Chief Executive Officer (or their respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise stated.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in these Bylaws, the Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the Executive Committee.

5.F. SPECIAL TASK FORCES

Special task forces shall be created and their members and chairpersons shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.

ARTICLE SIX **MEETINGS**

6.A. MEDICAL STAFF YEAR

The Medical Staff year is March 1 to the last day of February.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least four (4) times a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the Executive Committee, the Board, or by a petition signed by not less than one-fourth of the members of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws, each clinical department and committee shall meet at least quarterly, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the presiding officer, the Chief of Staff, or by a petition signed by not less than one-fourth of the Active Staff members of the clinical department, clinical section, or staff committee, but not by fewer than two (2) members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

- (a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of clinical departments, sections, and committees at least two (2) weeks in advance of the meetings. Notice may also be provided by posting in a designated location at least two (2) weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.
- (b) When a special meeting of the Medical Staff, a clinical department and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Posting may not be the sole mechanism used for providing notice.
- (c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, clinical department, section, or committee, those voting members present shall constitute a quorum. For meetings of the Executive and Credentials Committees, the presence of at least 50% of the total Committee shall constitute a quorum.
- (b) Recommendations and actions of the Medical Staff, clinical departments, sections, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.
- (c) The voting members of the Medical Staff, a clinical department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the chairperson by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.
- (d) Meetings may be conducted by telephone conference.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, clinical department, section, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff clinical department, section, or committee custom shall prevail at all meetings, and the department chief or committee chairperson shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

- (a) Minutes of all meetings of the Medical Staff, departments, and committees (and applicable section meetings) shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.
- (b) A summary of all recommendations and actions of the Medical Staff, clinical departments, sections, and committees shall be transmitted to the Executive Committee and Chief Executive Officer. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees.
- (c) A permanent file of the minutes of all meetings shall be maintained by the Medical Center.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to or are the subjects of credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Medical Staff Bylaws or other applicable Medical Staff or Medical Center policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

- (a) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable clinical department, section, and committee meetings each year.
- (b) At a minimum, however, each Active Staff member is required to attend 50% of applicable clinical department and committee meetings in each year.
- (c) A staff member who is compelled to be absent from the annual or any regular Medical Staff meeting shall submit his or her request for excused absence prior to the meeting. Unless excused for cause by the Executive Committee, the failure to meet the foregoing annual attendance requirements shall be grounds for a professional review action, including revocation of Medical Staff membership. Reinstatement of a staff member whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for one (1) initial appointment.
- (d) Each committee member shall be required to attend not less than fifty percent (50%) of all meetings of his or her committees in each year. The reasons provided for any absences and the action of the committee chairperson concerning the absences shall be shown in the minutes. The failure to meet the foregoing annual attendance requirements, unless excused by the committee chairperson for good cause shown, shall be grounds for a professional review action, including revocation of Medical Staff membership. Each committee chairperson shall report such attendance failures to the Executive Committee for action.

ARTICLE SEVEN
INDEMNIFICATION

The Medical Center shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chiefs, committee chairpersons, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Medical Center's corporate bylaws.

ARTICLE EIGHT
CLINICAL DEPARTMENTS

8.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

- (1) Clinical departments shall be created and may be consolidated or dissolved by the Executive Committee upon approval by the Board as set forth below.
- (2) The following factors shall be considered in determining whether a clinical department should be created:
 - (a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in this manual and in the bylaws);
 - (b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;
 - (c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;
 - (d) it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department; and
 - (e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.
- (3) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:
 - (a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in this manual or in the bylaws;
 - (b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;
 - (c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;
 - (d) no qualified individual is willing to serve as chief of the department; or
 - (e) a majority of the voting members of the department vote for its dissolution.

8.B. LIST OF CLINICAL DEPARTMENTS

The Medical Staff shall be organized into the Department of Medicine and the Department of Surgery.

8.C. FUNCTIONS AND RESPONSIBILITIES OF CLINICAL DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, sections, department chiefs, and section coordinators are set forth in Article Four (4): *Staff Departments*, of the Medical Staff Bylaws.

ARTICLE NINE
MEDICAL STAFF COMMITTEES

9.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article Five (5): *Medical Staff Committees and Performance Improvement Functions*, of the Medical Staff Bylaws.

9.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Executive Committee and to other committees and individuals as may be indicated in this Manual.

9.C: BYLAWS COMMITTEE

9.C.1. Composition:

The Bylaws Committee shall consist of three (3) members of the Active Staff, one of whom shall be appointed Chairperson.

9.C.2. Duties:

The Bylaws Committee shall review, on an ongoing basis, and at least once every two (2) years, the bylaws, policies, and rules and regulations of the Medical Staff and recommend any additions, revisions, modifications, amendments, or deletions, in order that all bylaws documents:

- (a) remain in compliance with all applicable federal and state laws and regulations, and applicable accreditation standards;
- (b) remain current with the Medical Staff's organization, structure, functions, responsibilities, and accountabilities; and
- (c) remain consistent with Medical Center policies.

9.D: CREDENTIALS COMMITTEE

9.D.1. Composition:

The Credentials Committee shall consist of the Chief of Medicine, the Chief of Surgery, and at least two (2) other members of the Active Staff who are the voting membership. In addition to the Chief Executive Officer, the ex-officio members without vote shall also include a designated representative from the Medical Staff Services Office.

9.D.2. Duties:

The Credentials Committee shall:

- (a) in accordance with these Bylaws, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a

- thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
- (b) in accordance with these Bylaws, review the credentials of all applicants seeking to practice as Advanced Practitioners, Advanced Mid-Level Practitioners or Dependent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
 - (c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations; and
 - (d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Medical Center, including clinical privileges for new procedures and clinical privileges that cross specialty lines as set forth in these Bylaws.

9.E: MEDICAL EDUCATION COMMITTEE

9.E.1. Composition:

The Medical Education Committee shall consist of no fewer than three (3) Active Staff members, representative of each clinical department, who are in good standing. The Director of Physician Services shall serve as an *ex officio* member of the committee.

9.E.2. Duties:

The Medical Education Committee shall:

- (a) perform the key function of continuing medical education under the oversight and direction of the Executive Committee;
- (b) plan, implement, coordinate and promote ongoing clinical and scientific education programs for the Medical Staff members and other individuals with clinical privileges;
- (c) establish liaison with the quality assessment and performance improvement program to identify the educational needs based on the findings from the program;²⁶
- (d) assist in prioritizing plans for Medical Center-sponsored education;²⁷
- (e) ensure provision of any required Medical Staff education, including:
 - (i) education about illness and health issues specific to physicians and other individuals with clinical privileges;²⁸
 - (ii) education about unprofessional or inappropriate conduct and its potential impact on patient safety;
 - (iii) Central line–associated bloodstream infections and the importance of prevention;²⁹
 - (iv) health care–associated infections, multidrug-resistant organisms,

²⁶ MS.12.01.01

²⁷ MS.12.01.01

²⁸ MS.12.01.01

²⁹ NPSG.07.04.01

- and prevention strategies;³⁰
- (v) surgical site infections and the importance of prevention;³¹
 - (vi) education about assessing and managing patients with pain;³²
 - (vii) At a minimum, education about the influenza vaccine; non- vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza;³³
 - (viii) education that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission;³⁴
 - (ix) education regarding a practitioner's role(s) in emergency response and to whom he or she reports during an emergency;³⁵
 - (x) education for licensed independent practitioners who perform waived testing;³⁶
 - (xi) education regarding minimizing, eliminating and reporting environmental risks;³⁷
 - (xii) alternative procedures to follow when electronic information systems are unavailable.³⁸
- (f) elect appropriate teaching methods and knowledgeable faculty for each education program;
 - (g) promote and document attendance at each program, and assess the effectiveness of each program;
 - (h) make recommendations regarding the library needs of the Medical Staff; and
 - (i) make recommendations regarding the financial needs of the continuing education program.

9.F: MEDICINE/SPECIAL CARE COMMITTEE

9.F.1. Composition:

The Medicine/Special Care Committee shall consist of at least nine (9) Medical Staff members with representation from Emergency Services, Family Practice, Internal Medicine, Surgery and any other specialty designated by the Chief of Medicine. Representatives from Administration, Nursing and Quality Management/Risk Management shall serve as *ex officio* members of the Committee.

9.F.2. Duties:

The Medicine/Special Care Committee shall:

- (a) conduct patient care management;
- (b) conduct risk management activities;

³⁰ NPSG.07.03.01

³¹ NPSG.07.05.01

³² MS.03.01.03

³³ IC.02.04.01

³⁴ APR.09.02.01

³⁵ EM.02.02.07

³⁶ WT.03.01.01

³⁷ EC.03.01.01

³⁸ IM.01.01.03

- (c) develop and approve written criteria for patient admission to and discharge from critical care areas, including the priority of admission and discharge from these areas;
- (d) develop policies and procedures concerning the scope and provision of care in the critical care areas;
- (e) conduct case review, including Risk Management and CQI activities for the Emergency Department, ICU, IMC and Radiology;
- (f) report findings of activities to the Quality Improvement Council for its conclusions, recommendations, actions and results of actions taken;
- (g) review and evaluate referrals from other committees and departments;
- (h) recommend to the Quality Improvement Council and Executive Committee topics/programs for the Medical Staff;
- (i) review infection control findings and take action to prevent and to control hazardous infection situations;
- (j) review those mortalities that meet established criteria for review; and
- (k) review blood use processes performed by the Medical Center, except in the OR, such as:
 - (i) ordering of whole blood and its components;
 - (ii) distributing, handling, dispensing, and administering these products; and
 - (iii) monitoring blood and blood component effects on patients.

9.G: PHARMACY AND THERAPEUTICS COMMITTEE

9.G.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least three (3) members of the Active Staff appointed from the Departments of Medicine and Surgery. Representatives from Administration, Nursing, Pharmacy, Case Management and Quality Management/Risk Management shall serve as *ex officio* members of the Committee.

9.G.2. Duties:

The Pharmacy and Therapeutics Committee shall:

- (a) develop a formulary accepted for use in the Medical Center;
- (b) be responsible for adding to and deleting from the list of drugs accepted for use in the Medical Center. The criteria used to evaluate drugs will include the indication for use, effectiveness, risks and costs;
- (c) prevent unnecessary duplication of stock of the same basic drug and its preparations;
- (d) periodically review obsolete drugs stocked in the pharmacy for the purpose of deletion from the formulary;
- (e) review formulary for safety and efficacy at least annually;
- (f) serve as an advisory group to the Medical Center pharmacy on matters pertaining to the choice of drugs;
- (g) recommend drugs to be stocked on the nursing unit and by other services;
- (h) develop or approve policies and procedures relating to all steps in the medication management process, including, selection, procurement, distribution, handling and use, administration, safety, monitoring and evaluation of drugs;

- (i) study any problems related to the administration of medications, including medication error rate, near miss information, and adverse drug reactions;
- (j) establish or plan programs of communication to the professional staff on pertinent matters related to drugs;
- (k) develop a drug utilization plan and perform a drug use evaluation and review of antibiotic sensitivity;
- (l) evaluate the appropriate use of high-risk drugs; and
- (m) periodically evaluate the pharmaceutical services provided and make appropriate recommendations.

9.H: QUALITY IMPROVEMENT COUNCIL COMMITTEE

9.H.1. Composition:

The Quality Improvement Council Committee shall consist of five (5) members of the Active Staff, one of whom shall serve as Chairperson. The Chief Nursing Officer and representatives from Administration and Quality Management/Risk Management shall serve as *ex officio* members of the Committee.

9.H.2. Duties:

The Quality Improvement Council Committee shall:

- (a) receive, review, evaluate and act upon quality improvement reports of the various Medical Center and Medical Staff departments, ancillary and nursing departments, and Quality Action Teams;
- (b) ensure that department directors and department chiefs are kept informed of the accreditation standards and informed of the accreditation status of the Medical Center;
- (c) account to the Medical Staff with regard to the quality of care rendered to patients in the Medical Center;
- (d) assist in the development, implementation, and periodic revision of the Quality Improvement Program;
- (e) ensure that monitoring and evaluation are completed in an integrated manner;
- (f) identify and investigate clinical problems and make recommendations for actions that include an educational focus;
- (g) maintain communication with the Safety/Risk Management Committee by sharing and utilizing the same data base as is prudently feasible;
- (h) when requested by the Executive Committee, investigate and determine whether grounds for discipline of a physician or staff member is indicated, in accordance with the Medical Staff Bylaws; and
- (i) submit reports of conclusions, recommendations, actions taken, and results of actions taken to the Executive Committee on a monthly basis and to the Board of Trustees on a quarterly basis.

9.I: RADIATION SAFETY COMMITTEE

9.I.1. Composition:

The Radiation Safety Committee shall consist of members of the Active Staff, including at least one (1) physician who represents each type of use of radiation devices and radioactive materials permitted in the Medical Center.

9.I.2. Duties:

The Radiation Safety Committee shall meet at least every six (6) months and shall act as the managerial body responsible for the safe and proper use of all radiation devices and radioactive materials within the Medical Center.

9.J: RESOURCE MANAGEMENT COMMITTEE

9.J.1. Composition:

The Resource Management Committee shall consist of at least five (5) members of the Medical Staff. Representatives from Nursing, Pharmacy, Laboratory, Imaging, Utilization Management, Quality Management/Risk Management, Health Information Management and Administration shall serve as *ex officio* members of the Committee.

9.J.2. Duties:

The Resource Management Committee shall:

- (a) oversee the proper content, organization and maintenance of individual patient records by random inpatient chart reviews, as well as discharged patients and emergency room records. The Committee is authorized to question any physician whose chart may be under review, but may not initiate corrective action with regard to any Medical Staff member or allied health professional. However, the Committee may inform the responsible individual that a record is deficient, improper or delinquent and, if the deficiencies are not corrected, refer the matter to the Executive Committee for action;
- (b) present information obtained through the exercise of its responsibilities to the Medical Staff for educational purposes and to improve patient care;
- (c) develop, maintain and execute an effective Utilization Management Plan, and assure that the functions required by the Plan are performed and documented in a proper and timely manner;
- (d) promote efficient utilization of beds and services through concurrent and retrospective reviews for inpatient admission, appropriate length of stay and the appropriate use of diagnostic and therapeutic facilities;
- (e) establish a plan to provide quality health care and assure the patient that the care is medically necessary, delivered in the most economical way by using the least expensive facilities and services available that will assure quality of care;
- (f) develop programs, policies, and procedures and monitor patient care comparing with DRG and other federal reimbursement programs;
- (g) monitor and evaluate the appropriateness and medical necessity of admissions, continued stay and supportive services;
- (h) identify utilization problems, which include, but are not limited to, overutilization, underutilization and inefficient scheduling of resources;

- (i) review and evaluate annually the Utilization Management Plan and revise as necessary;
- (j) review and evaluate the discharge planning process;
- (k) conduct the medical record review for clinical pertinence and timely completion; and
- (l) recommend and report to the Executive Committee on symbols and abbreviations used in the medical record and chart content and structure.

9.K: SURGICAL COMMITTEE

9.K.1. Composition:

The Surgical Committee shall consist of at least three (3) Active Staff members appointed from the Department of Surgery. The OR Supervisor, Chief Nursing Officer, the recording secretary, and representatives from Administration and Quality Management/Risk Management shall serve as *ex officio* members of the Committee.

9K.2. Duties:

The Surgical Committee shall:

- (a) review surgical procedures comparing pre- and post-operative diagnoses with pathological findings for consistencies and inconsistencies and using predetermined criteria to assure appropriateness of surgery;
- (b) review medical records for appropriateness of surgical procedures as documented by preoperative indications;
- (c) review all major invasive diagnostic procedures, including endoscopies;
- (d) review cases with complications or those not in compliance with predetermined criteria during monthly Patient Care Accountability Program (PCAP) screens (i.e., deaths during or following elective surgery; injuries, repair or unplanned removal of organs or structures during surgery; unplanned returns to OR; post-operative bleeding requiring transfusions; unplanned transfers to ICU following surgery);
- (e) review problems within the Department of Surgery;
- (f) review surgical quality assurance processes and procedures;
- (g) review infection control processes and procedures in the operating room; and
- (h) review blood usage in the operating room.

9.L: CANCER COMMITTEE

9.L.1. Composition:

The Cancer Committee shall be multidisciplinary committee whose chairperson shall be appointed by the Chief of Staff. The physician membership required by the Commission on Cancer shall consist of at least five (5) members of the Medical Staff: diagnostic radiologist, general surgeon, pathologist, medical oncologist and radiation oncologist; one physician member will be designated as the Cancer Liaison Physician. Required non-physician members are the Cancer Program Administrator, Oncology Nurse, Case Manager or Social Worker, Certified Tumor Registrar and Performance Improvement or Quality Management. Membership may include additional physician or non-physician

members from other disciplines, i.e. Pain Control Specialist, Clinical Research Data Specialist, Dietary, Pharmacy, Pastoral Care, Psychiatry, American Cancer Society Representative and a lay member.

9.L.2.Duties:

The Cancer Committee is responsible and accountable for goal setting, planning, designing, initiating, implementing, evaluating and improving all cancer related service activities. The Cancer Committee develops, monitors and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and overall program activities of cancer care service.

The duties of the Cancer Committee include:

- (a) providing program leadership for all aspects of oncology care;
- (b) providing direction for cancer program activities and serve as the basis for cancer program evaluation;
- (c) establishing, monitoring and evaluating the cancer conference frequency and format;
- (d) establishing, monitoring and evaluating the multidisciplinary attendance requirements for cancer conferences;
- (e) ensuring that the required number of cases are discussed at the cancer conference on an annual basis and that at least 75% of the cases discussed are presented prospectively;
- (f) establishing and implementing a plan to evaluate the quality of the cancer registry data and activity;
- (g) analyzing patient outcomes and disseminating the results;
- (h) developing recommendations for providing care and improving coordination of care;
- (i) implementing two improvements annually that directly affect cancer patient care;
- (j) facilitating two community outreach prevention or early detection programs annually;
- (k) ensuring that all requirements are met for accreditation by the American College of Surgeons Commission on Cancer; and
- (l) meet at least quarterly.

9.M: PRACTITIONER HEALTH COMMITTEE

9.M.1. Composition:

The Practitioner Health Committee shall be composed of three (3) voting members who shall be active staff members in good standing. Practitioner Health Committee members shall be selected based on their knowledge, skills and expertise in identification and management of practitioner health issues. Practitioner Health Committee members shall be appointed by the Chief of Staff.

9.M.2. Duties

The Practitioner Health Committee shall perform the key functions of the Practitioner Health program as outlined in Article Fourteen (14): *Peer Review Procedures for Questions Involving Medical Staff members*, in the Section related to Practitioner Health Issues.³⁹ The Practitioner Health Committee shall:

- (a) Recommend education for all Medical Staff and Hospital staff regarding practitioner health issues, including how to identify and report potential issues;
- (b) Develop and recommend policies for the Practitioner Health Program, such policies to include self referral, referral by others, evaluating credibility of a reported concern, resources for evaluation, diagnosis and treatment, maintaining confidentiality, monitoring practitioners under rehabilitation, intervening when patient safety is at risk, and taking appropriate actions;
- (c) Evaluate self-referrals and third party reports regarding potential practitioner health issues;
- (d) Conduct investigations of potential practitioner health issues;
- (e) Make recommendations for treatment and rehabilitation regarding practitioner health issues;
- (f) Monitor individuals under treatment and rehabilitation for practitioner health issues;
- (g) Make recommendations for reinstatement of clinical privileges following an individual's treatment and rehabilitation for practitioner health issues.

9.M.3. Meetings And Reporting

The Practitioner Health Committee shall meet at least annually to review the Practitioner Health program and policies, and shall determine the frequency of other meetings based on frequency of activities related to reporting and monitoring practitioner health issues.

³⁹ MS.11.01.01

ARTICLE TEN
QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

10.A. QUALIFICATIONS

10.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, podiatrists, and clinical psychologists must:

- (a) have a current, unrestricted license to practice in the State of Florida and have never had a license to practice revoked or suspended by any state licensing agency. If the applicant is an active duty military practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then licensure from any State shall be accepted. If the applicant is a telemedicine provider located in a different State, the applicant must also possess licensure in that State.⁴⁰
- (b) where applicable to their practice, have a current, unrestricted DEA registration with the applicant's in-state address for the State of Florida and/or state controlled substance certification/licensure. If the applicant is an active duty military practitioner, and will be prescribing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then DEA registration with an address from any State shall be accepted. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA⁴¹ and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.⁴²
- (c) be located (primary or satellite office and permanent or temporary residence) within a reasonable distance and/or travel time ("reasonable" to be developed by the Executive Committee and approved by the Board based on the staff member's specialty and scope of care at the Medical Center) to provide continuous care to their patients. The Board may, in its discretion, establish a minimum number of patient admissions or patient contacts that shall be made by members of the Active Staff. Medical Center-based practitioners (anesthesiologists, Emergency Department physicians, pathologists, and radiologists) who do not admit patients may be members of the Medical Staff if otherwise qualified;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center for initial granting of clinical privileges and to cover the term of the individual's clinical privileges. An applicant for Medical Staff membership only, with no clinical privileges, shall not be required to provide proof of professional liability insurance coverage;

⁴⁰ §482.26(c)(1)

⁴¹ MS.06.01.07

⁴² MS.06.01.07

- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (h) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (i) agree to fulfill all responsibilities regarding emergency call;
- (j) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual shall be unavailable;
- (k) demonstrate recent active clinical practice during at least two of the last four years; Medical Center based practitioners (Emergency Department physicians and Radiologists) may apply for Consulting Staff category if able to demonstrate active clinical practice during the past two (2) years at another facility (for Emergency Department physicians the staff category at another facility may be emergency department, emergency medicine or emergency room, etc. and for radiologists affiliated with Night Hawk Radiology the staff category at another facility may be telemedicine, i.e. teleradiology, telerads);
- (l) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") for allopathic physicians or the American Osteopathic Association ("AOA") for osteopathic physicians or that is accredited by the American Dental Association for dentists, or that is accredited by the Council on Podiatric Medical Education for podiatrists, in the specialty in which the applicant seeks clinical privileges;.*⁴³ Unless the applicant has graduated from a residency or fellowship program within 12 months of submitting an application, the applicant shall document participation in continuing education as related to the clinical privileges requested.

⁴³ MS.06.01.03, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)

- (m) be certified in their primary area of practice at the Medical Center by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS") or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association ("AOA") or the American Board of Physician Specialties ("ABPS"), or the American Association of Oral and Maxillofacial Surgery ("ABOMS"), or American Board of Podiatric Surgery ("ABPS"), or the American Board of Professional Psychology. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five (5) years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training; and*
- (n) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.*
- (o) submit a signed Physician Acknowledgement Statement which must be completed at the time he or she is granted admitting privileges at the hospital, or before the first patient encounter at the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

* These requirements shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy (January 16, 2007). These requirements are not applicable to existing Medical Staff members at any facility. Existing Medical Staff members shall be grandfathered and shall be governed by the residency training and board certification requirements in effect at the time of their initial appointments.

10.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chief, and the best interests of the Medical Center and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Executive Committee. Any recommendation to grant a waiver must include the basis for such.
- (c) The Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

- (d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.
- (e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

10.A.3. Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards shall be appointed to the Medical Staff. The following factors shall be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, demonstrated current competence, and judgment;
- (b) adherence to the ethics of their profession;
- (c) good reputation and character;
- (d) ability to perform, safely and competently, the clinical privileges requested;
- (e) ability to work harmoniously with all members of the patient care team;
- (f) recognition of the importance of, and willingness to support, the Medical Center's commitment to quality care, and recognition that interpersonal skills at collaboration, communication, and collegiality with patients, families, and other members of the health care team are essential for the provision of quality patient care;
- (g) ability to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
- (h) demonstrated knowledge of biomedical, clinical and social sciences, and the application of the practitioner's knowledge to patient care and the education of others;
- (i) ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices;
- (j) demonstrated behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward the practitioner's patients, profession, and society; and
- (k) demonstrated understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

10.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Medical Center; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

10.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.

10.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

10.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all bylaws, policies, and rules and regulations of the Medical Center and Medical Staff in force during the time the individual is appointed;
- (c) to accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to also comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;
- (e) to inform the Chief Executive Officer and the Chief of Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues (physical or mental), including impairment due to addiction;
- (f) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;
- (g) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two (2) Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team (Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or Chief Nursing Officer)) are concerned with the individual's ability to safely and competently care for patients and failure to take action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Medical Center. If there is no imminent danger to the health and/or safety of any individual, the situation will be referred to the Executive Committee. The Executive Committee may request that the member agree to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation.

The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership;

- (h) to appear for personal interviews in regard to an application for initial appointment or reappointment;
- (i) to use the Medical Center sufficiently to allow continuing assessment of current competence;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (l) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (m) to seek consultation whenever necessary;
- (n) to participate in monitoring and evaluation activities;
- (o) to complete in a timely manner all medical and other required records, containing all information required by the Medical Center;
- (p) to participate in an Organized Health Care Arrangement with the Medical Center, to abide by the terms of the Medical Center's Notice of Privacy Practices with respect to health care delivered in the Medical Center, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;
- (q) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (r) to promptly pay any applicable dues, assessments and/or fines;
- (s) to satisfy continuing medical education requirements;
- (t) abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice; and
- (u) that any misstatement in, or omission from, is grounds for the Medical Center to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Executive Committee. The Executive Committee will recommend to the Board whether the application should be processed further.

10.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the HCA Credentials Processing Center (CPC) or the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (b) As part of the annual reappointment process, these members shall be required to have a physical and mental health assessment performed by a practitioner who is

acceptable to the Credentials Committee. The examining practitioner shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining practitioner shall provide this report directly to the Credentials Committee and shall be available to discuss any questions or concerns that the Credentials Committee may have.

- (1) If the Credentials Committee determines that there are issues in any of these areas and/or other concern areas, the Credentials Committee shall determine what next steps are to be taken to address the concerns raised. The Credentials Committee may meet with the individual to discuss these concerns and to try to determine what collegial and voluntary steps, such as a voluntary restructuring of privileges, further monitoring, or focused review (as examples only), can be taken.
- (c) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given are accurate.
- (d) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (e) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.
- (f) All physicians and other practitioners shall submit a signed Physician Acknowledgement Statement. The physician or other practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.⁴⁴ Physicians, other Practitioners, and Allied Health Professionals will also sign a Confidentiality and Security Agreement at the time of application for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.⁴⁵

⁴⁴ 42 C.F.R. §412.46(c)

⁴⁵ HCA Ethics & Compliance Policy IS.SEC.005

10.C. APPLICATION

10.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff membership or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;⁴⁶
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged; information regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;⁴⁷
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested and the names of at least two peers who will provide written evaluation of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal;⁴⁸ and
 - (5) identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of Medical Staff Services provided that the applicant physically presents himself/herself for the verification process before the application may be considered complete.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

⁴⁶ MS.06.01.07

⁴⁷ MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement

⁴⁸ MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)

10.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

- (i) whether or not appointment or clinical privileges are granted;
- (ii) throughout the term of any appointment or reappointment period and thereafter; and
- (iii) as applicable, to any third-party inquiries received about his/her tenure at the Medical Center after the individual leaves the Medical Staff.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Medical Center, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request and agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Medical Center.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Medical Center and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE ELEVEN
PROCEDURE FOR INITIAL APPOINTMENT

11.A. PROCEDURE FOR INITIAL APPOINTMENT

11.A.1. Application:

- (a) A separate credentials record shall be maintained for each potential applicant for staff membership or clinical privileges.⁴⁹ Each Request for Consideration (RFC) or Recredentialing Request for Consideration (R-RFC) for Staff appointment, reappointment, and/or clinical privileges shall be in a prescribed format and signed by the applicant.
- (b) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken until all applicable eligibility criteria are satisfied.

11.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the HCA Credentials Processing Center (CPC) within 30 days after receipt. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application shall be reviewed by the HCA Credentials Processing Center (CPC) to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria shall be notified that their application shall not be processed.
- (c) The HCA Credentials Processing Center (CPC) shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

11.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, letters from professional schools, letters from postgraduate education programs, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (b) Additional inquiry shall be conducted by the Department Chairperson, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving

⁴⁹ 42 C.F.R. §482.22(a)(2), Guidance to Surveyors

questions about the application. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chief, the Credentials Committee, a Credentials Committee representative, the Executive Committee and/or the Chief of Staff. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees. Criteria for additional inquiry are:

- (1) inability to verify any of the information or credentials represented in the application;
- (2) unexplained gaps in medical staff membership, clinical privileges and/or work history;
- (3) any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees.

11.A.4. Department Chief Procedure:

- (a) The Medical Staff Services Department shall transmit the complete application and all supporting materials to the chief of each department in which the applicant seeks clinical privileges. Each chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The department chief may also recommend that an application raises no questions and should be considered for expedited processing.
- (c) The department chief shall be available to the Credentials Committee, Executive Committee, and the Board to answer any questions that may be raised with respect to that chief's report and findings.

11.A.5. Expedited Process:

- (a) If recommended by the relevant department chief, applications for initial appointment may be processed as set forth in this Section so long as they meet the following conditions:
 - (1) the applicant has successfully completed a residency in the specialty for which privileges are requested, with a consistent and excellent record, with no disciplinary actions taken or conditions imposed during residency training;
 - (2) all reference evaluations are completed and received within a reasonable time of the initial request;
 - (3) all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;
 - (4) the applicant's claims activity (including past malpractice claims, judgments and settlements) is reasonable in light of his or her specialty, and there has been no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;
 - (5) there are no current or previously successful challenges to licensure or registration;

- (6) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of Medical Staff appointment or clinical privileges at any hospital or other entity;
 - (7) there has been no investigation into and no disciplinary action taken relating to appointment or clinical privileges at any hospital or other entity; and
 - (8) no member of the Medical Staff has raised a question about the applicant's qualifications.
- (b) The Chairperson of the Credentials Committee, acting on behalf of the Committee, shall review the report from each department chief and all relevant information and prepare a report containing a recommendation on appointment, clinical privileges, and department assignment. This report shall be forwarded to the Chief of Staff.
 - (c) The Chief of Staff shall review the report and recommendation made by the Chairperson of the Credentials Committee. If the Chief of Staff concurs with the recommendation, the recommendation shall be forwarded to the Chief Executive Officer.
 - (d) The Chief Executive Officer, in consultation with the Chief of Staff, may grant the individual temporary clinical privileges, for a period not to exceed 120 days.
 - (e) After determining that an applicant is otherwise qualified for appointment and privileges, the Chairperson of the Credentials Committee shall determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If there is no question, the temporary privileges shall take effect. If there is a question, the application shall be referred to the full Credentials Committee for further action.
 - (f) If the department chief, the Chairperson of the Credentials Committee, the Chief of Staff, or the Chief Executive Officer has any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.
 - (g) A report regarding all applicants who are granted temporary clinical privileges shall be forwarded to the Credentials Committee for information, and the application for appointment and clinical privileges shall be forwarded to the Executive Committee for review and recommendation, and to the Board for final action.

11.A.6. Full Credentials Committee Procedure:

- (a) For all other applications, the Credentials Committee shall review and consider the report prepared by the relevant department chief and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chief, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s)

satisfactory to the Credentials Committee. The cost of examination shall be borne by the applicant. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

11.A.7. Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:
 - (1) adopt the findings and recommendation of the Credentials Committee, as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the Chief Executive Officer.
- (c) If the recommendation of the Executive Committee would entitle the applicant to request a hearing, the Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice to the applicant. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived a hearing and appeal.

11.A.8. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two (2) Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Executive Committee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Medical Center for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairperson of the Credentials Committee and the Chairperson of the Executive Committee. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

11.A.9. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

11.A.10. Credentials Subject to Ongoing Verification

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension actions as provided in these Bylaws and shall be reported to the Credentials Committee:

- (a) Current licensure;
- (b) Drug Enforcement Administration registration;
- (c) Professional liability insurance;
- (d) Specialty board certification;
- (e) Eligible to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List and the State Exclusion List shall be checked according to the frequencies defined by hospital policy.)

11.A.11. Conditional Appointment, Reappointment or Privileges

- (1) Recommendations for appointment, reappointment, initial granting of privileges and/or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., ' general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute a disciplinary action or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an

individual to request the procedural rights set forth in Article Fifteen (15): *Hearing and Appeal Procedures* of these Bylaws.

- (a) If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.
 - (b) If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Fourteen (14): *Peer Review Procedures for Questions Involving Medical Staff Members* of these Bylaws shall commence.
 - (c) If the individual refused to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed as part of a conditional appointment, reappointment, or privileges, then corrective actions as set forth in Article Fourteen (14): *Peer Review Procedures for Questions Involving Medical Staff Members* of these Bylaws shall commence.
- (2) Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of and individual's compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Fifteen (15): *Hearing and Appeal Procedures* of these Bylaws.
 - (3) In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.
 - (4) To end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment and privileging procedures.

11.B. PROVISIONAL STATUS

11.B.1. Duration of Provisional Period:

- (a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial clinical privileges shall be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee.
- (b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period shall be recommended by the Credentials Committee, after consulting with the department chief, and approved by the Board.

- (c) During the provisional period, the individual shall be evaluated by the chief of the department in which the individual has clinical privileges and by the relevant committees as to the individual's clinical competence and general behavior and conduct in the Medical Center.

11.B.2. Duties of Provisional Members:

- (a) The provisional member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the department chief or designated observers.
- (b) If the provisional member fails to: (1) admit or treat the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or (2) fulfill all requirements of appointment relating to meeting attendance, completion of medical records, emergency service call responsibilities, and/or cooperation with monitoring or observation conditions, at the expiration of provisional appointment, the individual's Medical Staff appointment and all clinical privileges shall be automatically relinquished and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for initial appointment or privileges for two (2) years.
- (c) If a member of the Medical Staff who has been granted additional clinical privileges or other individual granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two (2) years.
- (d) If a member of the Medical Staff or other individual with clinical privileges who has been in a provisional period for an evaluation of competence fails to participate in the required number of cases or cooperate with the monitoring and observation conditions, the clinical privileges under review shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two (2) years.
- (e) Whenever provisional appointment or provisional clinical privileges are terminated, -revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

ARTICLE TWELVE
CLINICAL PRIVILEGES

12.A. CLINICAL PRIVILEGES

12.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Medical Center.
- (b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (c) The grant of clinical privileges includes responsibility for emergency service call established to fulfill the Medical Center's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
- (d) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.
- (e) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with applicable contracts.
- (f) The clinical privileges recommended to the Board for each applicant shall be based upon consideration of the following regarding the applicant's qualifications:
 - (1) education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and health status as related to ability to perform the privileges requested competently and safely;
 - (2) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;
 - (3) adequate professional liability insurance coverage for the clinical privileges requested;
 - (4) the Medical Center's available resources and personnel;
 - (5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (6) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (7) practitioner-specific data compared to aggregate data, when available;
 - (8) morbidity and mortality data, when available;
 - (9) the results of the Medical Center's performance improvement activities, ongoing professional performance evaluations, focused professional performance evaluations, and professional and peer review activities, when available;
 - (10) ability to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
 - (11) demonstrated knowledge of biomedical, clinical and social sciences, and the application of the practitioner's knowledge to patient care and the education of others;
 - (12) ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices;

- (13) demonstrated interpersonal and communication skills that enable the practitioner to establish and maintain professional relationships with patients, families, and other members of health care teams;
 - (14) demonstrated behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward the individual's patients, profession, and society; and
 - (15) demonstrated understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
- (g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
 - (h) The report of the chief of the clinical department in which privileges are sought shall be forwarded to the Chairperson of the Credentials Committee and processed as a part of the initial application for staff appointment.
 - (i) A request by an individual with clinical privileges for additional clinical privileges or an increase in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:
 - (1) Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be verified.⁵⁰
 - (2) Training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be verified.⁵¹
 - (3) Evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant practitioner-specific performance data when available.⁵²
 - (4) An evaluation provided by peers of the applicant shall be included in deliberations when adding or increasing privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.⁵³
 - (5) Applicants are required to report malpractice insurance coverage information for the new privileges or increased clinical privileges requested, and claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.⁵⁴

⁵⁰ MS.06.01.05

⁵¹ MS.12.01.01

⁵² MS.06.01.05

⁵³ MS.06.01.05

⁵⁴ MS.06.01.05

- (6) The hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested.⁵⁵
- (7) When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified.⁵⁶
- (8) When adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:
 - (i.) Previously successful or currently pending challenges, or voluntary or involuntary relinquishment, of licensure or registration.⁵⁷
 - (ii) Voluntary or involuntary reduction in privileges or termination of privileges or membership.⁵⁸
 - (iii) Involvement in any liability actions, including any final judgments or settlements.⁵⁹
- (9) The basis for granting an additional clinical privilege(s) or an increase in clinical privilege(s) to a Medical Staff member with a record of competent professional performance at the Medical Center shall include information from the Medical Staff member's professional practice evaluation data.

12.A.2. Voluntary Relinquishment of Privileges:

- (a) A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the Executive Committee specifying the clinical privilege(s) to be relinquished and the reasons for the request. The department chief shall make a recommendation to the Executive Committee.
- (b) The Executive Committee may request a meeting with the member involved. The Executive Committee shall make a recommendation to the Board.
- (c) The Board shall make a final decision on the request, based upon, among other factors, how the request shall affect the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. The Board's decision shall be reported in writing by the Chief Executive Officer to the member, the Executive Committee, and the applicable department chief. If the Board permits the relinquishment of privileges, it shall specify the effective date of the relinquishment. The request to relinquish privileges shall not be effective until confirmed by the Board.
- (d) Failure of a member to request relinquishment of clinical privileges as set forth above shall result in the member being maintained on the call schedule without any change to his or her call responsibilities.

⁵⁵ MS.06.01.05; 42 U.S.C. §11135, C.F.R. §60.10

⁵⁶ MS.06.01.05

⁵⁷ MS.06.01.05

⁵⁸ MS.06.01.05

⁵⁹ MS.06.01.05

- (e) Members must maintain competency for the core privileges in their specialty. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage OR to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.

12.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure ("new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Medical Center and (2) criteria to be eligible to request those clinical privileges have been established.
- (b) The Credentials Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Medical Center has the capabilities, including support services, to perform the new procedure.
- (c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Medical Center, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

12.A.4. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that traditionally at the Medical Center have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).
- (c) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Credentials Committee may develop recommendations regarding:

- (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the extent of monitoring and supervision that should occur if privileges would be granted;
 - (4) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and
 - (5) the impact, if any, on emergency call responsibilities.
- (d) The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

12.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chief of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

12.A.6. Clinical Privileges for Podiatrists:

- (a) The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery. A medical history and physical examination of each patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all

appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

12.A.7. Clinical Privileges for Clinical Psychologists:

- (a) The scope and extent of psychological procedures that a psychologist or clinical psychologist may perform at this Medical Center shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Psychological procedures performed by psychologists shall be under the overall supervision of the Chairperson of the Department of Psychiatry. A medical history and physical examination pertinent to the patient's general health shall have taken place and been recorded in the medical record by a physician appointed to the Medical Staff before psychological services shall be provided, and a designated physician shall be responsible for the admission and medical care of the patient throughout the period of hospitalization.
- (c) The psychologist or the psychological team of which a psychologist is a member shall be responsible for the psychological care of the patient, including the psychological history and the testing of the patient, and shall make such documentation in the patient's medical record as appropriate and necessary for the care and safety of the patient. The medical record documentation shall be consistent with the Medical Staff Rules and Regulations, and in compliance with Medical Center and Medical Staff Bylaws, this Policy, and applicable state laws and/or regulations.

12.A.8. Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate department chief, the Credentials Committee, and the Executive Committee.
- (b) Individuals applying for telemedicine privileges shall meet the qualifications for medical staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements and emergency call responsibilities. In addition to meeting all other qualifications for clinical privileges, the following credentialing procedures shall be followed:
 - (1) When a telemedicine provider is providing services from a different State, licensure will be verified for both the State where the hospital is located and the State where the practitioner is located.
 - (2) Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries will be limited to the top five high volume affiliations and any healthcare organization from which the practitioner was reassigned during the last five years.
- (c) Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted pursuant to a contractual agreement shall be incident to and coterminous with the agreement.
- (d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant,

except that the Medical Center may utilize the credentialing information provided by the applicant's primary hospital/group, provided that hospital/group is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

- (e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Medical Center with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Medical Center, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.
- (f) Individuals granted telemedicine privileges shall be subject to the Medical Center's performance improvement and professional and peer review activities.

12.B. TEMPORARY CLINICAL PRIVILEGES

12.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Non-Applicants. Temporary privileges may be granted to non-applicants by the Chief Executive Officer, in consultation with the Chief of Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following: (i) the care of a specific patient or specific group of patients; or (ii) when necessary to prevent a lack or lapse of services in a needed specialty area. The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure within this State, unrestricted DEA registration reflecting an in-state address for the State of Florida, if applicable, current competence, evidence of ability to perform the privileges requested, current professional liability coverage acceptable to the Medical Center, results of a query to the National Practitioner Data Bank, results of any criminal background check, a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care, and verify status as an Ineligible Person. The grant of clinical privileges in these situations shall not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the Chief Executive Officer, in consultation with the Chief of Staff.
- (b) Locum Tenens. The Chief Executive Officer may grant temporary admitting and clinical privileges to an individual serving as a locum tenens for a member of the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in paragraph (a) of this section, except with respect to time periods. The individual serving as a locum tenens may exercise privileges for a maximum of 120 days, consecutive or not, any time during the 24-month period following the date they are granted.
- (c) Applicants. Temporary privileges may also be granted by the Chief Executive Officer, in consultation with the Chief of Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Executive Committee and Board, following a favorable

recommendation of the Credentials Committee. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure within this State, unrestricted DEA registration reflecting an in-state address for the State of Florida, if applicable,, relevant training or experience, current competence, ability to exercise the privileges requested and current professional liability coverage; compliance with privileges criteria; consideration of information from the Data Bank and from a criminal background check; a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care, and verify status as an Ineligible Person. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility. Temporary privileges in this situation shall be granted for a maximum period of 120 consecutive days.

- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Medical Center.
- (e) Sanction Checks. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by hospital policy.

12.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chief. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

12.B.3. Termination of Temporary Clinical Privileges:

- (a) The Chief Executive Officer may, at any time after consulting with the Chief of Staff and the Chairperson of the Credentials Committee, or the department chief, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer may, after consulting with the Chief of Staff and the department chief, immediately terminate all temporary privileges. The department chief or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (c) The granting of temporary privileges is a courtesy and may be terminated for any reason.
- (d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

12.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the department chief or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

12.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
 - (b) A volunteer's license may be verified in any of the following ways:
 - (i) current Medical Center picture ID card that clearly identifies the individual's professional designation;
 - (ii) current license to practice;
 - (iii) primary source verification of the license;
 - (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups;
 - (v) identification by a current Medical Center or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.
- (3) Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital,⁶⁰ and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.
- (4) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Medical Center.
- (5) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary

⁶⁰EM.02.02.13

source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

- (6) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners.⁶¹ This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Medical Center.

12.E. CONTRACTS FOR SERVICES

From time to time, the Medical Center may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Medical Center. All individuals functioning pursuant to such contracts shall obtain and maintain Medical Staff appointment and/or clinical privileges at the Medical Center, in accordance with the terms of this Policy.

12.F. MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a Qualified Physician, a Qualified Oralmaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.⁶² A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.⁶³ An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.⁶⁴

⁶¹ EM.02.02.13

⁶² MS.01.01.01, 42 C.F.R. §482.22(c)(5)(i)

⁶³ 42 C.F.R. §482.22(c)(5)(i)

⁶⁴ 42 C.F.R. §482.22(c)(5)(i)

ARTICLE THIRTEEN
PROCEDURE FOR REAPPOINTMENT

13.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

13.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) For individuals requesting clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application shall be considered complete and processed further; and
- (f) paid the reappointment processing fee.

13.A.2. Factors for Evaluation:

The following factors shall be evaluated as part of the reappointment process for each applicant:

- (a) current clinical competence, judgment and technical skill in the treatment of patients;
- (b) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Medical Center;
- (c) participation in Medical Staff duties, including committee assignments and emergency call;
- (d) behavior at the Medical Center, including the ability to work harmoniously with all members of the patient care team, support for the Medical Center's commitment to quality care, and interpersonal skill at collaboration, communication, and collegiality with patients, families and other members of the health care team, and a recognition that these skills are essential for the provision of quality patient care;
- (e) use of the Medical Center's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
- (f) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;

- (g) capacity to satisfactorily treat patients as indicated by the results of the Medical Center's performance improvement activities, ongoing professional performance evaluations, and professional and peer review activities;
- (h) appropriate resolution of any verified complaints received from patients and/or staff;
- (i) ability to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
- (j) demonstrated knowledge of biomedical, clinical and social sciences, and the application of the practitioner's knowledge to patient care and the education of others;
- (k) ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices;
- (l) demonstrated behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward the practitioner's patients, profession, and society;
- (m) demonstrated understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care; and
- (n) other reasonable indicators of continuing qualifications.

13.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least four (4) months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Credentials Processing Center within 30 days.
- (b) Failure to return a completed application within this time frame shall result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least two (2) months prior to the expiration of the member's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
- (c) Reappointment shall be for a period of not more than two (2) years.
- (d) Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.
- (e) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the Chief Executive Officer shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the Chief Executive Officer shall consult with the chief of the applicable department, the Chairperson of the Credentials Committee, or the Chief of Staff. The temporary clinical privileges shall be only for a period not to exceed 120 days.

- (f) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.
- (g) The application shall be reviewed by the Credentials Processing Center to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.
- (h) The Credentials Processing Center shall oversee the process of gathering and verifying relevant information. The Credentials Processing Center shall also be responsible for confirming that all relevant information has been received.

13.A.4. Processing Applications for Reappointment:

- (a) The Medical Staff Services Department shall forward the application to the relevant department chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment, except that applications for reappointment and renewal of clinical privileges shall not be eligible for the expedited process. Applications for reappointment and renewal of clinical privileges shall instead be processed through the full Credentials Committee and the Executive Committee.
- (b) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the Chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

13.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 15.A.1(a) of these Bylaws; the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Fifteen (15): *Hearing and Appeal Procedures*, of these Bylaws.
- (b) In addition, reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two (2) years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Fifteen (15): *Hearing and Appeal Procedures*, of these Bylaws.

13.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 14
PEER REVIEW PROCEDURES FOR QUESTIONS
INVOLVING MEDICAL STAFF MEMBERS

14.A. COLLEGIAL INTERVENTION

- (1) These Bylaws encourage the use of progressive steps by Medical Staff leaders and Medical Center management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct (including unethical, unprofessional, inappropriate, disruptive or harassing, including sexual harassment). The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) All collegial intervention efforts by Medical Staff leaders and Medical Center management are part of the Medical Center's performance improvement activities, and professional and peer review activities, and ongoing and focused professional practice evaluation activities.
- (3) These efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:
 - (a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
 - (b) proctoring, monitoring, consultation, and letters of guidance; and
 - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (4) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual shall have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Medical Center management.
- (6) The Chief of Staff, in conjunction with the Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another policy, such as the policy on practitioner health, the code of conduct policy, or the peer review policy, or to direct the matter to the Executive Committee for further determination.

14.B. INVESTIGATIONS

14.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

- (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the bylaws, policies, rules and regulations of the Medical Center or the Medical Staff; and/or
 - (3) conduct by any member of the Medical Staff that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff, including the inability of the member to work harmoniously with others,
- the matter may be referred to the Chief of Staff, the chief of the department, the chairperson of a standing committee, the Chief Executive Officer, and/or the Chairperson of the Board.
- (b) The person(s) to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Executive Committee.
 - (c) No action taken pursuant to this Section shall constitute an investigation.

14.B.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to proceed in another manner. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.
- (b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.
- (d) The Chief of Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

14.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician).
- (b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It

shall also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that

- (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
 - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
- (c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The cost shall be borne by the individual being investigated. The individual being investigated shall also execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
- (1) relevant literature and clinical practice guidelines, as appropriate;

- (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
- (3) any information or explanations provided by the individual under review.

14.B.4. Recommendation:

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring or consultation;
 - (5) recommend additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; and/or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

14.C. PRECAUTIONARY SUSPENSION OR RESTRICTION
OF CLINICAL PRIVILEGES

14.C.1. Grounds for Precautionary Suspension or Restriction:

- (a) The Chief of Staff and the Chief Executive Officer or the chief of the department and the Chief Executive Officer, or the Board Chairperson and the Chief Executive Officer shall have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation whenever a practitioner or other individual with clinical privileges

willfully disregards these Bylaws or the Medical Staff Rules & Regulations or Hospital Policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the hospital, or to prevent interference with the orderly operation of the Medical Center. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

- (b) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction. The Chief of the Department to which a suspended or restricted practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the practitioner's patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute practitioner. A suspended or restricted practitioner's elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another practitioner as requested by each patient.

14.C.2. Executive Committee Procedure:

- (a) As soon as possible after such precautionary suspension, the Executive Committee shall be convened to review the matter resulting in a precautionary suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Medical Center, depending on the circumstances.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee must determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

14.C.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
- (b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chief, the Executive Committee, and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

14.D. AUTOMATIC RELINQUISHMENT

14.D.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by Health Information Management of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable rules and regulations shall result in automatic resignation from the Medical Staff.

14.D.2. Action by Government Agency or Insurer:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Chief Executive Officer.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:
 - (1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Medical Center or cease to be in effect, in whole or in part.
 - (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
 - (5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.
- (c) Automatic relinquishment shall take effect immediately upon notice to the Medical Center and continue until the matter is resolved, if applicable.
- (d) Failure to resolve the underlying matter leading to an individual's clinical privileges automatically relinquished in accordance with paragraphs (b)(1), (b)(2) or (b)(3) above, within 60 days of the date of relinquishment shall result in automatic resignation from the Medical Staff. If an individual engages in any patient contact after the occurrence of an event that results in automatic relinquishment, without notifying the Medical Center of that event, the relinquishment shall be deemed permanent.
- (e) Requests for reinstatement shall be reviewed by the relevant department chief, the Chairperson of the Credentials Committee, the Chief of Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the

Credentials Committee, Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

14.D.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for Medical Staff membership or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information within a timeframe specified in the written request, will result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

14.D.4. Failure to Attend Special Conference:

- (a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chief or the Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this conference shall be given by special notice at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
- (c) Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

14.E. LEAVES OF ABSENCE

A Medical Staff member may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and include the reasons for the request. The request shall not exceed ninety (90) day increments which shall not exceed a total leave of absence for one (1) year. The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer and Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees. During the period of leave, the Practitioner shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff member requesting the leave. The granting of a leave of absence, or reinstatement, as appropriate, may be

conditioned upon the individual's completion of all medical records. Exceptions shall be allowed only in the event that a Medical Staff member has a physical or psychological condition that prevents him/her from completing records or concluding the Medical Staff or Hospital matters. A leave of absence may be granted for the following reason:

14.E.1. Medical Leave Of Absence

Members of the Medical Staff must report to the Chief Executive Officer any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. A Medical Staff member may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue (as defined in Section 14.F. *Practitioner Health Issues* below). If an individual is unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Chief of Staff or Chairperson of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of the action.

14.E.2. Military Leave of Absence

A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

14.E.3. Educational Leave of Absence

A Medical Staff member may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Four (4): *Staff Departments*, of these Bylaws.

14.E.4. Personal/Family Leave of Absence

A Medical Staff member may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors Without Borders/USA") or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave. During the leave of absence the Medical Staff member may not be on active staff at another hospital and may not maintain a full time private practice in the community/service area.

14.E.5. Reinstatement Following a Leave of Absence

The Medical Staff member on leave of absence must request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes

have occurred in the status of any of the credentials listed in Article Ten (10): *Qualifications, Conditions and Responsibilities*, Article Eleven (11): *Procedure for Initial Appointment*, Article Twelve (12): *Clinical Privileges*, and Article Thirteen (13): *Procedure for Reappointment*, or if changes have occurred, a detailed description of the nature of the changes. The Staff member shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the section of these Bylaws addressing practitioner health issues (Section 14.F). If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Ten (10): *Qualifications, Conditions and Responsibilities*, Article Twelve (12) *Clinical Privileges*, and Article Thirteen (13): *Procedure for Reappointment*, of these Bylaws and the reinstatement shall be processed as a reappointment. The Chief of Staff will forward the request for reinstatement to the individual's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Twelve (12): *Clinical Privileges*, Section 12.A. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

14.E.6. Absence For Longer Than One Year

Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff and the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

14.E.7. Leaves of Absence Are Matters of Courtesy

Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, this will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

14.E.8. Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from

a Medical Staff member deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for reappointment.

14.F. PRACTITIONER HEALTH ISSUES

This section of the bylaws applies to all individuals who provide patient care services in the hospital and who have been granted clinical privileges. The hospital and its medical staff are committed to providing quality care, which can be compromised if an individual with clinical privileges is suffering from a health issue. "Health issue" means any physical, mental, or emotional condition, or personality disorder including alcohol or substance abuse, cognitive deterioration or loss of motor skills due to the aging process, and use of prescription medications, which could adversely affect an individual's ability to practice safely and competently.^{65,66} It also includes a contagious disease which could compromise patient safety or jeopardize other health care workers. The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges for the purpose of facilitating the timely recognition and reporting of health issues. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges has a health issue. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).

14.F.1 Self-Reporting

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.⁶⁷

- (a) An oral or preferably, a written report shall be given to the Chief Executive Officer, the President/Chief of Staff, and/or the chairperson of the individual's Medical Staff department and/or the Chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Medical Executive Committee or the Practitioner Health Committee.

⁶⁵ MS.11.01.01

⁶⁶ AMA Definition of Impairment

⁶⁷ MS11.01.01

14.F.2. Third Party Reports

- (1) If a Medical Staff member, Allied Health Professional, or Hospital employee witnesses symptoms of a health issue they should report the incident. Patients, family members, or others who witness symptoms of a health issue shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting symptoms of a health issue shall be kept strictly confidential.⁶⁸ Medical Staff members and others, as appropriate, shall be educated about recognition of health issues specific to physicians and others with clinical privileges, including education about warning signs.⁶⁹ Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.
 - (a) An oral or, preferably, a written report shall be given to the Chief Executive Officer, the President/Chief of Staff, the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee or the Practitioner Health Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may have a health issue. The person making the report does not need to have proof of the health issue, but must state the facts leading to the concern.
 - (b) If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:
 - (i) Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,
 - (ii) Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Practitioner Health Committee.

14.F.3. Concerns Requiring An Immediate Response

- (1) Anyone who is concerned that an individual has a health issue that poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant Department Chairperson, the Chief of Staff (or their designees).
- (2) The Department Chairperson and/or Chief of Staff (or their designees) shall immediately assess the individual and, if necessary to protect patients, may relieve the individual of patient care responsibilities. The affected individual's hospitalized patients may be assigned to another individual with appropriate clinical privileges or to the appropriate practitioner on call. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The affected patients shall be informed that their practitioner is unable to proceed with their care due to illness.
- (3) Following the immediate response, the Department Chairperson and/or Chief of Staff (or their designees) shall file formal reports as described in these Bylaws, in order

⁶⁸ MS11.01.01

⁶⁹ MS11.01.01

for the health issue to be more fully assessed and addressed by the Practitioner Health Committee.

14.F.4. Review By Practitioner Health Committee

- (1) The Practitioner Health Committee shall act expeditiously in reviewing concerns regarding a potential health issue. As part of its review, the Practitioner Health Committee may meet with the individual(s) who initially reported the concern.
- (2) If the Practitioner Health Committee believes that the practitioner has or might have a health issue, it shall meet with the individual. At this meeting, the individual should be told that there is a concern that his or her ability to practice safely and competently may be compromised by a health issue and advised of the nature of the concern, but should not be told who initially reported the concern.
- (3) The Practitioner Health Committee may require that the individual (i) undergo a physical or mental examination, (ii) submit to an alcohol or drug screening test (blood, hair, or urine), and/or (iii) be evaluated by a physician or organization and have the results of any such evaluation provided to it, in accordance with the Hospital policy regarding Medication Diversion. The Practitioner Health Committee shall select the health care professional(s) or organization to perform the testing and/or evaluation.
- (4) The Practitioner Health Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Practitioner Health Committee may ask the individual under investigation health-related questions. In addition, if the Committee feels that the individual may have a health issue that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

14.F.5. Outcome of Investigation

Based on all of the information it reviews as part of its investigation, the Practitioner Health Committee shall determine:

- (1) Whether the individual has a health issue, or what other problem, if any, is affecting the individual under investigation;
- (2) If the individual has a health issue, the nature of the health issue and whether it is classified as a disability;
- (3) If the individual's health issue is a disability, whether a reasonable accommodation can be made for the individual's health issue such that, with the reasonable accommodation, the individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;
- (4) Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,

- (5) Whether health issue could negatively impact the quality of care or the health or safety of the individual, patients, Hospital employees, physicians or others within the Hospital.
- (6) If the Practitioner Health Committee determines that there is a reasonable accommodation that ensures patient safety, the Practitioner Health Committee shall attempt to work out a voluntary agreement with the individual. The Chief Executive Officer shall be kept informed of the voluntary agreement before it becomes final and effective. Based on the severity and nature of the health issue, the Practitioner Health Committee may recommend to the practitioner that he or she:
 - (a) take a voluntary medical leave of absence to receive appropriate medical treatment or participate in a rehabilitation program; or
 - (b) voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or
 - (c) voluntarily agree to specific conditions.
- (7) If the Practitioner Health Committee recommends that the individual receive medical treatment or participate in a rehabilitation program, it may assist the individual in identifying appropriate resources.
- (8) If the individual does not agree to abide by the Practitioner Health Committee's recommendations, the matter shall be referred to the Medical Executive Committee for a review and possible investigation to be conducted pursuant to the Medical Staff Bylaws or any applicable credentials policy.
- (9) If the individual agrees to abide by the recommendations of the Practitioner Health Committee, a confidential report will be made to the applicable Department Chairperson, the Chief of Staff, and the Chair of the Credentials Committee. In the event any of these individuals is concerned that the action of the Practitioner Health Committee is not sufficient to protect patients or other health care workers, the matter will be referred back to the Practitioner Health Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for review and possible investigation.
- (10) If the Practitioner Health Committee determines that there is no reasonable accommodation that can be made or if the Practitioner Health Committee cannot reach a voluntary agreement with the individual, the Practitioner Health Committee shall refer the matter with a recommendation to the Medical Executive Committee. The Medical Executive Committee may conduct its own investigation or adopt the recommendation of the Practitioner Health Committee and shall make a recommendation and report to the Board of Trustees, as appropriate to the action to be taken. If the Practitioner Health Committee's recommendation would provide the individual with a right to a hearing as described in the Medical Staff Bylaws, the individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Fifteen (15): *Hearing and Appeal Procedures*, of the Medical Staff Bylaws.

- (11) The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credential file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual's credential file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee or the Credentials Committee or the Practitioner Health Committee.
- (12) Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in these Bylaws.

14.F.6. Treatment/Rehabilitation and Reinstatement Guidelines

If it is determined that the individual has a health issue that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

- (1) An individual with a health issue shall not be reinstated until it is established, to the Medical Executive Committee's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological health issue such that the condition is under sufficient control.
- (2) The Medical Executive Committee is not required to extend membership or privileges to an individual with a health issue, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.
- (3) Upon sufficient proof that the individual who has been found to have a health issue has completed a program or received treatment as described above, the Medical Executive Committee, in its discretion, may consider the individual for reinstatement of Medical Staff membership or clinical privileges.
- (4) In considering an individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.
- (5) The Medical Executive Committee must first obtain a letter from the physician director of the rehabilitation program where the individual was treated, or the physician directing the individual's medical or psychological treatment. The individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:
 - (a) Whether the individual is participating in the program or treatment;
 - (b) Whether the individual is in compliance with all of the terms of the program or treatment plan;
 - (c) Whether the individual attends AA/NA meetings regularly (if appropriate);
 - (d) To what extent the individual's behavior and conduct are monitored;
 - (e) Whether, in the opinion of the treating physician, the individual is rehabilitated or the health issue is under control;
 - (f) Whether any conditions are required to allow the individual to safely resume practicing (e.g., supervision, limitation on work hours, limitation on privileges);
 - (g) Whether an after-care program has been recommended to the individual (if appropriate), and if so, a description of the after-care program; and,

- (h) Whether, in the opinion of the treating physician, the individual is capable of resuming practice and providing continuous, competent care to patients.
- (6) The Medical Executive Committee has the right to require opinion(s) from other physician consultants of its choice. Before making a recommendation on a request for reinstatement or lifting conditions, the Practitioner Health Committee may request the practitioner to undergo an examination by a physician of its choice to obtain a second opinion on the practitioner's ability to practice safely and competently. The Practitioner Health Committee shall make a recommendation to the Medical Executive Committee.
- (7) Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
 - (a) The individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
 - (b) If the practitioner was granted a formal medical leave of absence, the final decision to reinstate an individual's clinical privileges must be approved pursuant to the Leave of Absence process set forth in the Medical Staff Bylaws;
 - (c) The individual shall be required to obtain periodic reports for the Medical Executive Committee from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.
- (8) The individual must agree to submit to an alcohol or drug-screening test (if appropriate) at the request of the Chief Executive Officer or designee, the President/Chief of Staff, the Chairperson of the Practitioner Health Committee, or the pertinent Department Chairperson.
- (9) As a condition of reinstatement, the individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with Article Ten (10): *Qualifications, Conditions and Responsibilities*, Article Eleven (11) *Procedure for Initial Appointment*, Article Twelve (12): *Clinical Privileges* and Article Thirteen (13): *Procedure for Reappointment* of these Medical Staff Bylaws. Minimally, licensure, DEA, state narcotics registration and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the health issue.
- 10) If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.
- (11) If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is

determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.⁷⁰

- (12) If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the individual or others, the President/Chief of Staff or Chief Executive Officer may contact law enforcement authorities.
- (13) Nothing in this Section precludes immediate referral to the Medical Executive Committee or the elimination of any particular steps in this Section in dealing with conduct that may compromise patient care.
- (14) All requests for information concerning the individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or Referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.⁷¹

⁷⁰ MS11.01.01

⁷¹ MS11.01.01

ARTICLE FIFTEEN
HEARING AND APPEAL PROCEDURES

15.A. INITIATION OF HEARING

15.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these recommendations without an adverse recommendation by the Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the Executive Committee" shall be interpreted as a reference to "the Board."

15.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) issuance of a letter of guidance, counsel, warning, or reprimand;
- (b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
- (h) determination that an application is incomplete;
- (i) determination that an application shall not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an exclusive contract.

15.A.3. Notice of Recommendation:

The Chief Executive Officer shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

15.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the Chief Executive Officer and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

15.A.5. Notice of Hearing and Statement of Reasons:

- (a) The Chief Executive Officer shall schedule the hearing and provide, by special notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

15.A.6. Witness List:

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

15.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:
The Chief Executive Officer, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as Chairperson;
 - (2) The Hearing Panel may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or
 - (ii) physicians not connected with the Medical Center (i.e., physicians not on the Medical Staff or not affiliated with the Medical Center);
 - (3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel;
 - (4) Employment by, or other contractual arrangement with, the Medical Center or an affiliate shall not preclude an individual from serving on the Panel;
 - (5) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing;
 - (6) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing, and
 - (7) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- (b) Presiding Officer:
- (1) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
 - (2) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.
 - (3) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence;
 - (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
 - (4) The Presiding Officer may be advised by legal counsel to the Medical Center with regard to the hearing procedure.
 - (5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Chief of Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. Alternatively, the Chief of Staff may appoint an attorney to be a legal consultant to the hearing panel. The hearing officer or legal consultant may be present during deliberations, but shall not vote.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing to the Chief Executive Officer within 10 days of receipt of notice. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The Chief Executive Officer shall rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

15.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

15.B. PRE-HEARING PROCEDURES

15.B.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

15.B.2. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
- (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.
- (d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Medical Center employees appearing on the Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

15.B.3. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

15.B.4. Stipulations:

The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

15.B.5. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

15.C. THE HEARING

15.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

15.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Medical Center. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

15.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
 - (5) to submit a written statement at the close of the hearing; and
 - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

15.C.4. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

15.C.5. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

15.C.6. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or the Chief of Staff.

15.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

15.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

15.D. HEARING CONCLUSION, DELIBERATIONS,
AND RECOMMENDATIONS

15.D.1. Order of Presentation:

The Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

15.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

15.D.3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

15.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Executive Committee.

15.E. APPEAL PROCEDURE

15.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

15.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with the bylaws of the Medical Center or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

15.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in this section, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

15.E.4. Nature of Appellate Review:

- (a) The Board may consider the appeal as a whole body, or the Chairperson of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).
- (d) The Review Panel shall recommend final action to the Board.

15.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee for its information.

15.E.6. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is

referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

15.E.7. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one (1) hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of three (3) years unless the Board provides otherwise

ARTICLE SIXTEEN
CONFLICTS OF INTEREST

- (a) When performing a function outlined in these Bylaws, or the Medical Staff Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.
- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict), or the applicable department chief or committee chair. The Chief of Staff or the applicable department chief or committee chairperson will make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a department chief or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.
- (d) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

ARTICLE SEVENTEEN
CONFIDENTIALITY AND PEER REVIEW PROTECTION

17.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Medical Center employee and are for the purpose of conducting legitimate credentialing and peer review activities;
- (2) when the disclosures are authorized by a Medical Staff or Medical Center policy; or
- (3) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

17.B. PEER REVIEW PROTECTION

- (1) All credentialing and peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with applicable state law. Peer review committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Medical Center committees;
 - (b) hearing panels;
 - (c) the Board and its committees;
 - (d) any individual acting for or on behalf of any such entity, including but not limited to department chiefs, section coordinators, committee chairpersons and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and
 - (e) all departments and sections;All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.
- (2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. '11101 *et seq.*

ARTICLE EIGHTEEN
SCOPE AND OVERVIEW OF ALLIED HEALTH PROFESSIONALS

18.A. SCOPE

- (1) These Bylaws address those allied health professionals who are permitted to provide services in the Medical Center. It also addresses those physicians who are not appointed to the Medical Staff, but who seek to exercise certain limited privileges at the Medical Center under the conditions set forth in these Bylaws (e.g., house physicians and moonlighting residents).
- (2) These Bylaws also set forth the credentialing process and the general practice parameters for allied health professionals, as well as guidelines for determining the need for additional categories of such practitioners at the Medical Center.

18.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of allied health professionals that have been approved by the Board of Trustees shall be permitted to practice at the Medical Center. All such categories shall be classified as either Dependent Practitioners, Advanced Mid-Level Practitioners, or Advanced Practitioners.
- (2) A current listing of the specific classes of allied health professionals functioning in the Medical Center as Advanced Practitioners is attached to these Bylaws as Appendix A. Advanced Mid-Level Practitioners are listed in Appendix B and attached herein. A current listing of the specific categories of allied health professionals functioning in the Medical Center as Dependent Practitioners is attached to these Bylaws as Appendix C. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the Executive Committee, without the necessity of further amendment of these Bylaws.

18.C. PROCESS FOR DETERMINING NEED FOR A NEW CLASS OF ALLIED HEALTH PROFESSIONALS

18.C.1. Review of Need:

- (a) Whenever an allied health professional requests to practice at the Medical Center, and the Board has not already approved the class of practitioner for practice at the Medical Center, the Chief Executive Officer shall appoint an ad hoc committee to evaluate the need for that class of allied health professional. The ad hoc committee shall report to the Executive Committee, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the allied health professional shall be invited to submit information about the nature of the proposed practice, the reason access to the Medical Center is sought, and the potential benefits to the community of having such services available at the Medical Center.
- (c) The ad hoc committee may consider the following factors when making a recommendation as to the need for the services of this class of allied health professional:
 - (1) the nature of the services that would be offered;

- (2) any state license or regulation which outlines the specific patient care services and/or activities that the allied health professional is authorized by law to perform;
- (3) any state "nondiscrimination" or "any willing provider" laws that would apply to the allied health professional;
- (4) the patient care objectives of the Medical Center, including patient convenience;
- (5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the allied health professional were provided at the Medical Center;
- (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
- (7) the availability of supplies, equipment, and other necessary Medical Center resources;
- (8) the need for, and availability of, trained staff to support the services that would be offered; and
- (9) the ability to appropriately supervise performance and monitor quality of care.

18.C.2. Additional Recommendations:

- (a) If the ad hoc committee makes a recommendation that there is a need for the particular class of allied health professional at the Medical Center, it shall also recommend:
 - (1) any specific qualifications and/or training that must be possessed beyond those set forth in these Bylaws;
 - (2) a detailed description of a scope of practice or clinical privileges;
 - (3) any specific conditions that apply to practice within the Medical Center; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the ad hoc committee shall consult the appropriate department chief(s) and consider relevant state law and may contact professional societies or associations. The ad hoc committee may also recommend the number of allied health professionals that are needed.

ARTICLE NINETEEN
QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

19.A. QUALIFICATIONS

19.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued scope of practice, or clinical privileges, allied health professionals shall, where applicable:

- (a) have a current, unrestricted license, certification or registration to practice in this state and have never had a license, certification or registration to practice revoked or suspended;
- (b) have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Medical Center, as defined by the Board, close enough to fulfill responsibilities and provide timely and continuous care for patients in the Medical Center;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;
- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same;
- (f) have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (g) have never had a scope of practice or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (i) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Medical Center;
- (j) if seeking to practice as a Dependent Practitioner, or as an Advanced Mid-Level Practitioner, have a written agreement with a member of the Medical Staff to provide the requisite supervision, which agreement must meet all applicable requirements of state law and Medical Center policy; and
- (k) be able to document their:
 - (1) relevant training, experience, demonstrated current competence and judgment;
 - (2) adherence to the ethics of their profession;
 - (3) good reputation and character;
 - (4) ability to perform, safely and competently, the clinical privileges or scope of practice requested;
 - (5) ability to work harmoniously with all members of the patient care team; and
 - (6) recognition of the importance of, and willingness to support, the Medical Center's commitment to quality care, and recognition that interpersonal skills at collaboration, communication, and collegiality are essential for the provision of quality patient care.

19.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy an eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, the Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Medical Center and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of scope of practice or clinical privileges.

19.A.3. No Entitlement to Medical Staff Appointment:

Allied health professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

19.A.4. Nondiscrimination Policy:

No individual shall be denied a scope of practice or clinical privileges at the Medical Center on the basis of gender, race, creed or national origin.

19.B. GENERAL CONDITIONS OF PRACTICE

19.B.1. Assumption of Duties and Responsibilities:

As a condition of being granted a scope of practice or clinical privileges, allied health professionals shall specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all bylaws, policies and rules and regulations of the Medical Center and Medical Staff;
- (c) to accept committee assignments, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;
- (e) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;
- (f) to inform the chief of the clinical department and the Chief Executive Officer of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure, certification or registration status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner's status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the

individual's ability to safely and competently exercise clinical privileges or scope of practice or perform duties and responsibilities because of health status issues (physical or mental), including impairment due to addiction;

- (g) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two (2) Medical Staff leaders (or one (1) Medical Staff leader and one (1) member of the management team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership. The cost of any screening or physical and/or mental examination shall be borne by the affected allied health professional.
- (h) to acknowledge that the individual has had an opportunity to read a copy of the Medical Staff Bylaws, policies, Rules and Regulations and agrees to be bound by them;
- (i) to appear for personal interviews as may be requested;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (l) to refrain from deceiving patients as to his or her status as an allied health professional;
- (m) to seek consultation when appropriate;
- (n) to participate in monitoring and evaluation activities;
- (o) to complete, in a timely manner, all medical and other required records containing all information required by the Medical Center;
- (p) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;
- (q) to satisfy applicable continuing education requirements;
- (r) to promptly pay any applicable dues and assessments;
- (s) abide by all local State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice; and
- (t) that any misstatement in, or omission from, the application form is grounds for the Medical Center to stop processing the application. If permission to practice has been granted prior to the discovery of a misstatement or omission, clinical privileges or scope of practice may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, of these Bylaws. The individual shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee shall review the individual's response and provide a recommendation to the Executive Committee. The Executive Committee shall recommend to the Board whether the application should be processed further.

19.B.2. Burden of Providing Information:

- (a) Allied health professionals seeking to practice shall have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of

current competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

- (b) Allied health professionals seeking to practice at the Medical Center have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) It is the responsibility of the individual seeking a scope of practice or clinical privileges to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

19.C. APPLICATION

19.C.1. Information:

- (a) The applications for allied health professionals shall be in the format prescribed by the hospital .
- (b) The applications shall require detailed information concerning the applicant's professional qualifications. In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's scope of practice or clinical privileges and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced, limited, terminated, or not renewed at any hospital or health care facility or is currently being investigated or challenged;
 - (2) information as to whether the applicant's license or certification to practice any profession in any state or DEA registration or any state controlled substance license is, or has ever been, voluntarily or involuntarily relinquished, suspended, modified, terminated, or restricted or is currently being investigated or challenged; information regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments or settlements, and the substance of the allegations, as well as the findings and the ultimate disposition; and
 - (4) current information regarding the applicant's ability to safely and competently exercise the scope of practice or clinical privileges he or she has requested.
- (c) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of allied health professionals.

19.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for a scope of practice or clinical privileges, the allied health professional expressly accepts the following conditions during the processing and consideration of the application, whether or not granted, and as an ongoing condition of practice, if granted:

- (a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any member of the Medical Staff, their authorized representatives, and

appropriate third parties for any matter relating to scope of practice or clinical privileges or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Medical Center, its authorized agents, or appropriate third parties.

- (b) Authorization to Obtain Information from Third Parties:
The allied health professional specifically authorizes the Medical Center, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for scope of practice or clinical privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request.
- (c) Authorization to Release Information to Third Parties:
The individual also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for scope of practice, clinical privileges, and/or participation at the requesting organization/facility.
- (d) Procedural Rights:
The allied health professional agrees that the procedural rights set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.
- (e) Legal Actions:
If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Medical Center, any member of the Medical Staff, and any other agent named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE TWENTY
CREDENTIALING PROCEDURE

20.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

20.A.1. Request for Application:

- (a) Any individual requesting to practice as an allied health professional shall meet the qualifications in Article Nineteen (19): *Qualifications, Conditions and Responsibilities*.
- (b) An allied health professional who is in a class of practitioners that has not been approved by the Board for access to the Medical Center shall be ineligible to receive an application. A determination of ineligibility does not entitle an allied health professional to the procedural rights outlined in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, of these Bylaws.

20.A.2. Submission of Application:

- (a) A completed application, with copies of all required documents, must be returned to the HCA Credentials Processing Center (CPC) within 30 days after receipt of the application if the allied health professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.
- (b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need arises for new, additional or clarifying information any time during the evaluation.
- (c) Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

20.A.3. Initial Review of Application:

- (a) As a preliminary step, the HCA Credentials Processing Center (CPC) shall review the application to determine that the individual satisfies all threshold criteria. An individual who fails to meet the eligibility criteria set forth in Section 19.A.1 of these Bylaws shall be notified that his or her application shall not be processed. A determination of ineligibility does not entitle an allied health professional to the procedural rights outlined in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, of these Bylaws.
- (b) The HCA Credentials Processing Center (CPC) shall also review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chief.

20.A.4. Review by Department Chief:

- (a) The Medical Staff Services Department shall transmit the complete application and all supporting materials to the appropriate department chief. Each chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for the scope of practice or clinical privileges requested.
- (b) In preparing this report, the department chief has the right to meet with the applicant, and the supervising physician (if applicable), to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The department chief may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, appropriate supervisor within the department, nurse managers).
- (c) The department chief shall be available to answer any questions that may be raised with respect to that chief's report and findings.

20.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the department chief and may interview the applicant. Thereafter, the Credentials Committee shall make a recommendation.
- (b) Based on information obtained during the application process, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Committee. The cost of examination shall be borne by the applicant. The results of this examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The Credentials Committee may refer an application to the Practitioner Health Committee for assistance in assessing the results of the examination and more generally the ability of the applicant to safely and competently practice.
- (c) The recommendation of the Credentials Committee that an applicant be granted the requested scope of practice or clinical privileges shall be forwarded to the Executive Committee or the Chief of Staff, as applicable.

20.A.6. Executive Committee Action on Dependent Practitioners:

- (a) For each applicant seeking to practice as a Dependent Practitioner, after receipt of the written findings and recommendations of the Credentials Committee, the Chief of Staff, acting on behalf of the Executive Committee, shall:
 - (1) adopt the findings and recommendations of the Credentials Committee;
or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised prior to a final recommendation; or
 - (3) state reasons in a report and recommendation, along with supporting information, for disagreement with the Credentials Committee's recommendation.

- (b) The recommendation of the Chief of Staff pertaining to Dependent Practitioners shall be forwarded to the Chief Executive Officer.
- (c) If the recommendation of the Chief of Staff would entitle the applicant to the procedural rights set forth in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, the Chief Executive Officer shall send the applicant special notice. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived the procedural process outlined in these Bylaws.

20.A.7. Executive Committee Action on Advanced Practitioners:

- (a) For each applicant seeking to practice as an Advanced Practitioner, at its next regular meeting, after receipt of the written findings and recommendations of the Credentials Committee, the Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) The recommendation of the Executive Committee shall be forwarded to the Board.
- (c) If the recommendation of the Executive Committee would entitle the applicant to the procedural rights set forth in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, the Chief Executive Officer shall send the applicant special notice. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived the procedural process outlined in these Bylaws.

20.A.8. Final Action on Applications for Dependent Practitioners:

- (a) Upon receipt of a recommendation from the Chief of Staff, pertaining to a Dependent Practitioner, the Chief Executive Officer may:
 - (1) grant the applicant a scope of practice; or
 - (2) refer the matter back to the Chief of Staff or to another source inside or outside the Medical Center for additional research or information; or
 - (3) reject or modify the recommendation and/or comment.
- (b) If the decision of the Chief Executive Officer is favorable, notice of the decision shall be sent to the Dependent Practitioner and the supervising physician, with a copy to the Executive Committee and the Credentials Committee.
- (c) If the preliminary decision of the Chief Executive Officer is unfavorable, the Chief Executive Officer should first discuss the matter with the Chief of Staff. If the Chief Executive Officer's decision remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to the procedural rights set forth in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, of these Bylaws.

20.A.9. Final Action on Applications for Advanced Practitioners:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Executive Committee and there is no evidence of any of the following:
- (1) a current or previously successful challenge to any license, certification or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of clinical privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
- Any decision reached by the Board Committee to grant clinical privileges shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.
- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation from the Executive Committee pertaining to an Advanced Practitioner, the Board may:
- (1) grant the applicant clinical privileges; or
 - (2) refer the matter back to the Credentials Committee or the Executive Committee or to another source inside or outside the Medical Center for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the decision of the Board is favorable, notice of the decision shall be sent to the Advanced Practitioner, with a copy to the Executive Committee and the Credentials Committee.
- (d) If the preliminary decision of the Board is unfavorable, the Chairperson of the Board should first discuss the matter with the Chief of Staff. If the Board's decision remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to the procedural rights set forth in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*, of these Bylaws.

20.B. TEMPORARY SCOPE OF PRACTICE OR TEMPORARY CLINICAL PRIVILEGES

20.B.1. Request for Temporary Scope of Practice or Temporary Clinical Privileges:

- (a) A temporary scope of practice or temporary privileges may be granted by the Chief Executive Officer, in consultation with the Chief of Staff, when an applicant has submitted a completed application and the application is pending review by the Executive Committee and the Board, following a favorable recommendation of the Credentials Committee (or its Chairperson). Prior to a temporary scope of practice or temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the scope of practice or privileges requested, and compliance with criteria, and consideration of information from the Data Bank. In order to be eligible for a temporary scope of practice, or temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or

involuntary limitation, reduction, denial, or loss of scope of practice or clinical privileges, at another health care facility.

- (b) Prior to a temporary scope of practice or temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, policies, procedures and protocols.
- (c) A temporary scope of practice or temporary privileges shall be granted for a specific period of time, not to exceed 120 days, and shall expire at the end of the time period for which they are granted.

20.B.2. Termination of Temporary Scope of Practice or Temporary Clinical Privileges:

- (a) The Chief Executive Officer may, in consultation with the Chief of Staff and the Chairperson of the Credentials Committee or the department chief, terminate a temporary scope of practice or temporary privileges for any reason.
- (b) The granting of a temporary scope of practice or temporary privileges is a courtesy. Neither the denial nor termination of a temporary scope of practice or temporary privileges shall entitle the individual to the procedural rights set forth in Article Twenty-three (23): *Procedural Rights of Allied Health Professionals*,.

20.C. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

20.C.1. Submission of Application:

- (a) The grant of a scope of practice, and the grant of clinical privileges, is a courtesy and, if granted, shall be for a period not to exceed two (2) years. A request to renew a scope of practice or clinical privileges shall be considered only upon submission of a completed renewal application.
- (b) At least four (4) months prior to the date of expiration of an allied health professional's scope of practice or clinical privileges, the HCA Credentials Processing Center (CPC) shall notify the individual of the date of expiration and provide the individual with a renewal application.
- (c) Failure to return a completed application at least two (2) months prior to the expiration of the individual's scope of practice or clinical privileges shall result in automatic expiration of such scope of practice or clinical privileges at the end of the then current term.
- (d) Once an application for renewal of scope of practice or clinical privileges has been completed and submitted to the Credentials Processing Center, it shall be evaluated following the same procedures outlined in these Bylaws regarding initial applications.

20.C.2. Renewal Process for Dependent Practitioners:

- (a) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria, shall be applicable in processing requests for renewal.
- (b) As part of the process for renewal of scope of practice, the following factors shall be considered:
 - (1) the annual competency assessments of the individual performed by the supervising physician(s) and the applicable Medical Center department heads or nurse managers; and
 - (2) resolution of any verified complaints received from patients or staff.

20.C.3. Renewal Process for Advanced Practitioners:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria, shall be applicable in processing requests for renewal.
- (b) As part of the process for renewal of clinical privileges, the following factors shall be considered:
 - (1) an assessment prepared by the applicable department chief;
 - (2) an assessment prepared by a peer;
 - (3) results of the Medical Center's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information concerning other individuals in the same or similar specialty; and
 - (4) resolution of any verified complaints received from patients or staff.
- (c) In addition to the above, the annual competency assessments of Advanced Mid-Level Practitioners by the supervising physician(s) and the applicable Medical Center department heads or nurse managers shall also be considered.

ARTICLE TWENTY-ONE
CONDITIONS OF PRACTICE APPLICABLE TO
DEPENDENT PRACTITIONERS AND ADVANCED
MID-LEVEL PRACTITIONERS

21.A. OVERSIGHT BY SUPERVISING PHYSICIAN

- (1) Dependent Practitioners and Advanced Mid-Level Practitioners may function in the Medical Center only so long as they have a supervising physician.
- (2) Any activities permitted to be performed at the Medical Center by a Dependent Practitioner or an Advanced Mid-Level Practitioner shall be performed only under the supervision or direction of the supervising physician.
- (3) It shall be the responsibility of the supervising physician to countersign all medical record entries made by his or her Dependent Practitioner or Advanced Mid-Level Practitioner in accordance with applicable policies and rules and regulations.
- (4) If the Medical Staff appointment or clinical privileges of a supervising physician are resigned, revoked or terminated, the Dependent Practitioner's scope of practice or Advanced Mid-Level Practitioner's clinical privileges shall automatically terminate. The Credentials Committee may, however, recommend that the Dependent Practitioner or Advanced Mid-Level Practitioner be permitted to arrange for another supervising physician.
- (5) As a condition of a scope of practice or clinical privileges, a Dependent Practitioner or Advanced Mid-Level Practitioner and the supervising physician must provide the Medical Center with notice of any revisions or modifications that are made to the supervision agreement. This notice must be provided to the Chief of Staff and Chief Executive Officer within three (3) days of any such change.

21.B. QUESTIONS REGARDING DEPENDENT PRACTITIONER OR ADVANCED
MID-LEVEL PRACTITIONER AUTHORITY

- (1) Should any member of the Medical Staff, or any employee of the Medical Center who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of a Dependent Practitioner or an Advanced Mid-Level Practitioner to act or issue instructions outside the presence of the supervising physician, such individual shall have the right to request that the supervising physician validate, either at the time or later, the instructions of the Dependent Practitioner or Advanced Mid-Level Practitioner. Any act or instruction of the Dependent Practitioner or Advanced Mid-Level Practitioner shall be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.
- (2) Any question regarding the conduct of a Dependent Practitioner or Advanced Mid-Level Practitioner shall be reported to the Chief of Staff, the Chairperson of the Credentials Committee, the relevant department chief, and/or the Chief Executive Officer for appropriate action.

21.C. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

- (1) The supervising physician shall remain responsible for all acts of the Dependent Practitioner or Advanced Mid-Level Practitioner in the Medical Center.
- (2) The number of Dependent Practitioners or Advanced Mid-Level Practitioners acting under the supervision of one Medical Staff member, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Medical Center. The supervising physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Dependent Practitioner or the Advanced Mid-Level Practitioner, to the extent that such filings are required.
- (3) It shall be the responsibility of the supervising physician to provide, or to arrange for, professional liability insurance coverage for the Dependent Practitioner or Advanced Mid-Level Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Dependent Practitioner or Advanced Mid-Level Practitioner in the Medical Center. The supervising physician shall furnish evidence of such coverage to the Medical Center. The Dependent Practitioner or Advanced Mid-Level Practitioner shall act in the Medical Center only while such coverage is in effect.

ARTICLE TWENTY-TWO
PEER REVIEW PROCEDURES FOR QUESTIONS
INVOLVING ALLIED HEALTH PROFESSIONALS

22.A. COLLEGIAL INTERVENTION

- (1) As part of the Medical Center's performance improvement and professional and peer review activities, these Bylaws encourages the use of progressive steps by Medical Staff leaders and administration to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) The Chief of Staff and the Chief Executive Officer shall determine whether to direct that a matter be handled in accordance with another policy, such as the code of conduct policy, or the peer review policy, or to direct the matter to the Credentials Committee or the Executive Committee for further review and/or investigation.

22.B. ADMINISTRATIVE SUSPENSION

- (1) The Chief Executive Officer, in consultation with the Chief of Staff, the Chairperson of the Credentials Committee, or the appropriate department chief shall have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any allied health professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Chairperson of the Credentials Committee, and shall remain in effect unless or until modified by the Executive Committee.
- (3) Upon notice of the imposition of an administrative suspension, the Credentials Committee shall review and consider the question(s) raised and thereafter make a recommendation to the Executive Committee for further action.

22.C. AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE
OR CLINICAL PRIVILEGES

The scope of practice or clinical privileges of an allied health professional shall be automatically relinquished, without entitlement to the procedural rights outlined in these Bylaws, in the following circumstances:

- (1) the allied health professional no longer satisfies any of the threshold eligibility criteria set forth in Section 19.A.1 or any additional threshold credentialing qualifications set forth in the specific Medical Center policy relating to his or her discipline;
- (2) the allied health professional is indicted for any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another;

- (3) the allied health professional fails to provide information within seven (7) days pertaining to his or her qualifications for the scope of practice or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information; or
- (4) a determination is made by the Executive Committee and approved by the Board that there is no longer a need for the services that are being provided by the allied health professional.

22.D. LEAVE OF ABSENCE

An Allied Health Professional (AHP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and include the reasons for the request. The request shall not exceed ninety (90) day increments which shall not exceed a total leave of absence for one (1) year. The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer and Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees. During the period of leave, the AHP shall not exercise clinical privileges at the Hospital, and AHP prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the AHP requesting the leave. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records. Exceptions shall be allowed only in the event that an AHP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

22.D.1. Medical Leave of Absence

An AHP must report to the Chief Executive Officer any time they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. An AHP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue as defined in Section 14.F. Practitioner Health Issues. If an individual is unable to request a medical leave of absence because of a physical or psychological or health issue condition, the Chief of Staff or Chairperson of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action.

22.D.2. Military Leave of Absence

An AHP may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of the deployment orders. An AHP who is on active military duty for more than one

year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of an AHP status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

22.D.3. Educational Leave of Absence

An AHP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of the additional education and training must be requested in accordance with Article Eighteen (18): *Scope and Overview Allied Health Professionals*, Article Nineteen (19): *Qualifications, Conditions and Responsibilities* and Article Twenty-one (21) *Conditions of Practice Applicable to Dependent Practitioners and Advanced Mid-Level Practitioners* of these Bylaws.

22.D.4. Personal/Family Leave of Absence

An AHP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to “Doctors Without Borders/USA”) or family reasons (e.g., maternity leave). Reinstatement of AHP status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave. During the leave of absence the AHP may not be actively practicing at another hospital and may not maintain a full time private practice in the community/service area.

22.D.5. Termination of Leave

The AHP on a leave of absence may request reinstatement of AHP affiliation and/or clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Eighteen (18), *Scope and Overview Allied Health Professionals*; Article Nineteen (19), *Qualifications, Conditions and Responsibilities*; and Article Twenty-one (21) *Conditions of Practice Applicable to Dependent Practitioners and Advanced Mid-Level Practitioners* or if changes have occurred, a detailed description of the nature of the changes. The AHP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the AHP’s reaffiliation time, he/she will be required to submit an application for reaffiliation in accordance with Article Nineteen (19), *Qualifications, Conditions and Responsibilities* and Article Twenty (20). *Credentialing Procedure* Section 20.C. of these Bylaws and the reinstatement shall be processed as a reaffiliation. An AHP applying for reinstatement may apply for temporary privileges while the request for reinstatement is being processed, in accordance with Article Twenty (20), *Credentialing Procedure* Section 20.B. The Chief of Staff will forward the request for reinstatement to the individual’s Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve

full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Eighteen (18) *Scope and Overview Allied Health Professionals*, Article Nineteen (19) *Qualifications, Conditions and Responsibilities* and Article Twenty-one (21) *Conditions of Practice Applicable to Dependent Practitioners and advanced Mid-Level Practitioners*. An adverse decision regarding reinstatement of AHP affiliation or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

22.D.6. Absence For Longer Than One Year

Absence for longer than one year will result in automatic relinquishment of clinical privileges unless an extension is granted by the Chief of Staff and the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

22.D.7. Leaves of Absence Are Matters of Courtesy

Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, this will result in automatic relinquishment clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

22.D.8. Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the AHP Staff and/or voluntary relinquishment of clinical privileges. A request for AHP affiliation or clinical privileges subsequently received from an AHP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for reappointment.

ARTICLE TWENTY-THREE
PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

23.A. GENERAL

Allied health professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. Any and all rights to which allied health professionals are entitled are set forth in these Bylaws.

23.B. PROCEDURAL RIGHTS FOR DEPENDENT PRACTITIONERS

- (1) In the event a recommendation is made by the Chief of Staff or the Chief Executive Officer that a Dependent Practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted, terminated, or not renewed, the individual shall receive special notice of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Chief of Staff and the Chief Executive Officer.
- (2) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The supervising physician and the Dependent Practitioner shall both be permitted to attend this meeting. However, no counsel for either party shall be present.
- (3) Following this meeting, the Chief Executive Officer, in consultation with the Chief of Staff, shall make a final decision.

23.C. PROCEDURAL RIGHTS FOR ADVANCED PRACTITIONERS

23.C.1. Notice of Recommendation and Hearing Rights:

- (a) In the event a recommendation is made by the Executive Committee that an Advanced Practitioner not be granted clinical privileges or that the privileges previously granted be restricted, terminated or not renewed, the individual shall receive special notice of the recommendation. The special notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing.
- (b) The rights and procedures in this Section shall also apply if the Board, without a prior adverse recommendation from the Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated or not renewed. In this instance, all references in this Article to the Executive Committee shall be interpreted as a reference to the Board.
- (c) If the Advanced Practitioner wants to request a hearing, the request must be in writing, directed to the Chief Executive Officer, within 30 days after receipt of written notice of the adverse recommendation.
- (d) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

23.C.2. Hearing Committee:

- (a) If a request for a hearing is timely made, the Chief Executive Officer, in consultation with the Chief of Staff, shall appoint a Hearing Committee composed of up to three (3) individuals (including, but not limited to, members

of the Medical Staff, allied health professionals, Medical Center management, or any combination of these individuals). The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Advanced Practitioner, or any competitors of the affected individual.

- (b) The Chief Executive Officer, in consultation with the Chief of Staff, shall appoint one of the Hearing Committee members to serve as Chairperson or may appoint a Presiding Officer ("Presiding Officer"), who may be legal counsel to the Medical Center. The role of the Hearing Committee Chairperson or the Presiding Officer shall be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Hearing Committee Chairperson or the Presiding Officer shall maintain decorum throughout the hearing.
- (c) As an alternative to a Hearing Committee, the Chief Executive Officer, in consultation with the Chief of Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

23.C.3. Hearing Process:

- (a) A record of the hearing shall be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript shall be available at the individual's expense.
- (b) The hearing shall last no more than four (4) hours, with each side being afforded approximately two (2) hours to present its case, in terms of both direct and cross-examination of witnesses.
- (c) At the hearing, a representative of the Executive Committee shall first present the reasons for the recommendation. The Advanced Practitioner shall be invited to present information to refute the reasons for the recommendation.
- (d) Both parties shall have the right to present witnesses. The Presiding Officer shall permit reasonable questioning of such witnesses.
- (e) The Advanced Practitioner and the Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel shall not call, examine, or cross-examine witnesses or present the case.
- (f) The Advanced Practitioner shall have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Executive Committee was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Medical Center shall be the paramount considerations.
- (g) The Advanced Practitioner and the Executive Committee shall have the right to prepare a post-hearing memorandum for consideration by the Hearing

Committee. The Presiding Officer shall establish a reasonable schedule for the submission of such memoranda.

23.C.4. Hearing Committee Report:

- (a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee shall prepare a written report and recommendation. The Hearing Committee shall forward the report and recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the written report and recommendation by special notice to the Advanced Practitioner, the Executive Committee and the Credentials Committee for information.
- (b) Within ten (10) days after notice of such recommendation, the Advanced Practitioner and/or the Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (c) The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with these Bylaws and/or other applicable bylaws or policies of the Medical Center and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.
- (d) The request for an appeal shall be delivered to the Chief Executive Officer by special notice.
- (e) If a written request for appeal is not timely submitted, the appeal is deemed to be waived and the recommendation and supporting information shall be forwarded to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer shall forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chairperson of the Board shall arrange for an appeal.

23.C.5. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chairperson of the Board shall consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review shall be conducted within 30 days after receiving the request for appeal.
- (b) The Advanced Practitioner and the Executive Committee shall each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the Advanced Practitioner and a representative of the Executive Committee may also appear personally to discuss their position.
- (d) Upon completion of the review, the Appellate Review Committee shall provide a report and recommendation to the full Board for action. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Medical Center.
- (e) The Advanced Practitioner shall receive special notice of the Board's action. A copy of the Board's final action shall also be sent to the Executive Committee and to the Credentials Committee for information.

ARTICLE TWENTY-FOUR
MEDICAL CENTER EMPLOYEES

- A. The employment of an allied health professional by the Medical Center shall be governed by the Medical Center's employment policies and manuals and the terms of the individual's employment relationship and/or written contract.
- B. A request for a scope of practice or clinical privileges, on an initial basis or for renewal, submitted by an allied health professional who is seeking employment or who is employed by the Medical Center, shall be processed in accordance with the terms of these Bylaws except that the Board shall not need to act upon the request. A report regarding each allied health professional's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Medical Center in making employment decisions.
- C. If an allied health professional's employment is terminated for any reason, the individual's scope of practice or clinical privileges shall automatically expire without any procedural rights set forth in these Bylaws.
- D. Except as otherwise provided above, to the extent that the Medical Center's employment policies or manuals, or the terms of any applicable employment contract, conflict with these Bylaws, the employment policies, manuals and descriptions, and terms of the individual's employment relationship and/or written contract shall apply.

**ARTICLE TWENTY-FIVE
ADOPTION AND AMENDMENT AND GENERAL PROVISIONS**

25.A. MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions.⁷² The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards.⁷³ The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. “Associated details” are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.⁷⁴

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.⁷⁵

25.B. EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

25.C. METHODOLOGY

25.C.1. Medical Staff Bylaws

Upon the request of the Medical Executive Committee, or the Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. If the proposed revision is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the revision via written notice of the proposed change to all voting members of the Medical Staff no less than twenty (20) days prior to the meeting at which the Bylaws changes are to be voted upon.⁷⁶ If the proposed revision is made by written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the revision via written notice of the proposed change to all members of the Medical Executive Committee no less than twenty (20) days prior to the meeting upon which the Bylaws changes are to be voted.⁷⁷ The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). If a quorum is present as

⁷² 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c)

⁷³ 42 C.F.R. §482.12(a)(3), Interpretive Guidelines

⁷⁴ MS.01.01.01

⁷⁵ 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c), MS.01.01.01

⁷⁶ MS.01.01.01

⁷⁷ MS.01.01.01

described in Article Six (6) *Meetings*, Section 6.D.2. *Quorum and Voting* for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person or by written ballot. In the event of a conflict within the Medical Staff regarding Medical Staff Bylaws, the Medical Staff process for conflict management shall be implemented. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff Policies, Medical Staff members shall be provided with a revised text.⁷⁸

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.⁷⁹

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below.⁸⁰ As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff.⁸¹ In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the Medical Executive Committee's or Medical Staff's approval, including using the conflict management process as set out below in Section 25.E.9. In such a situation, the Board's amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

⁷⁸ MS.01.01.01, MS.02.01.01, LD.03.04.01

⁷⁹ MS.01.01.01

⁸⁰ MS.01.01.03

⁸¹ 42 C.F.R. §482.12

25.C.2. Rules & Regulations And Medical Staff Policies

To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and Policies.

(a) Medical Staff Rules and Regulations and Policies: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Medical Staff also has the ability to adopt Rules and Regulations and Policies and any amendments thereto by obtaining a written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote. The Rules and Regulations and Policies proposed by petition shall then be communicated to the Medical Executive Committee and shall be subject to final approval of the Board. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

(b) Department Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Department shall formulate its own Department Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. The members of the Department may also propose Department Rules and Regulations and Policies directly to the Board after first communicating the proposal to the Medical Executive Committee and such proposal shall be subject to final approval of the Board. Such Department Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governance Bylaws of the Board of Trustees.

25.D. MECHANICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations and Policies.

25.E. GENERAL PROVISIONS

25.E.1. Successor In Interest

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

25.E.2. Affiliations

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

25.E.3. No Implied Rights

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

25.E.4. Notices

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

25.E.5. No Contract Intended

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Twenty-Five (25): *Adoption and Amendment and General Provisions*, and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

25.E.6. Conflict of Interest

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself/herself.

- (1) When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the

matter before leaving.

- (2) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Chief of Staff (or to the Vice Chief if the Chief of Staff is the person with the potential conflict), or the applicable Department Chairperson or Committee Chair. The Chief of Staff or the applicable Department Chairperson or Committee Chair will make a final determination as to whether the provisions in this Article should be triggered.
- (3) The fact that a Department Chairperson or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.
- (4) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

25.E.7. No Agency

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

25.E.8. Conflict

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

25.E.9. CONFLICT MANAGEMENT/RESOLUTION

25.E.9.1. Conflicts Between the Board and the Medical Executive Committee⁸²

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal

⁸² MS.01.01.01; LD.02.04.01

conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

25.E.9.2. Conflicts Between the Medical Staff and the Medical Executive Committee⁸³

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their

⁸³ MS.01.01.01

recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff, the representatives of the Medical Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- Three voting members of the Medical Staff representing the recommendations in the written petition
- The Chairperson of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

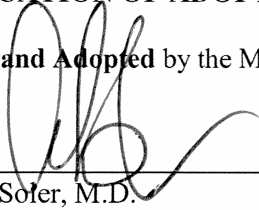
In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

25.E.10 Entire Bylaws

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

CERTIFICATION OF ADOPTION AND APPROVAL

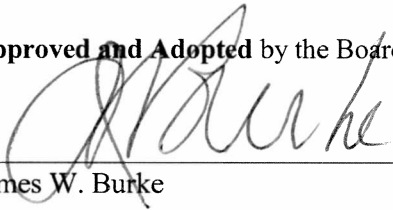
Approved and Adopted by the Medical Staff of **Lake City Medical Center** on July 13, 2011.



Alejandro Sofer, M.D.

President, Medical Staff

Approved and Adopted by the Board of Trustees of **Lake City Medical Center** on July 19, 2011.



James W. Burke

Chairman, Board of Trustees

APPENDIX A

Those allied health professionals currently practicing as Advanced Practitioners at Lake City Medical Center are as follows:

Medical Physicist

APPENDIX B

Those allied health professionals currently practicing as Advanced Mid-Level Practitioners at Lake City Medical Center are as follows:

Advanced Registered Nurse Practitioner
Certified Registered Nurse Anesthetist
Physician Assistant

APPENDIX C

Those allied health professionals currently practicing as Dependent Practitioners at Lake City Medical Center are as follows:

Registered Nurse - Oncology
Certified Scrub Technician
Dosimetrist
Health Care Industry Representative (HCIR)

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**RULES AND REGULATIONS
OF THE MEDICAL STAFF
OF
LAKE CITY MEDICAL CENTER**

**RULES & REGULATIONS
OF THE MEDICAL STAFF**

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**Rules & Regulations
May 15, 2007**

Revised: November 18, 2008; August 13, 2009; November 17, 2009; December 14, 2010; March 15, 2011; June 21, 2011

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A. **ADMISSION, TRANSFER, AND DISCHARGE**

A.1. Admitting/Treatment Privileges:

A patient may be admitted to Lake City Medical Center only by a member of the Medical Staff who has been granted Active Staff appointment and clinical privileges of this Hospital. Only practitioners granted clinical privileges may treat patients at this Hospital. All practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital.

A.2. Responsibility for Care of Hospital Patients:

A physician member of the Medical Staff shall be responsible for the overall medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, an order covering the transfer of responsibility shall be entered on the order sheet of the medical record and the responsible nurse shall be notified.

A.3. Provisional Diagnosis/Reason for Admission:

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. A copy of the emergency service record shall accompany the patient to the nursing unit.

A.4. Bed Availability- Bed Control:

In any case in which it appears the patient will have to be admitted to the Hospital, the physician or his designee shall, when possible, first contact Bed Control to ascertain whether there is an available bed.

A.5. Patient Admission

The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission and transfer priorities and proper review thereof. These shall be developed by each clinical department and/or section and approved by the Medical Executive Committee.

A.6. Emergency Admissions:

Practitioners shall be able to justify emergency admissions based on criteria developed by the Staff. The history and physical must clearly justify the patient being admitted on an emergency basis and all findings must be recorded on the patient's medical record as soon as possible after admission.

A.7. Care of Patients Admitted on Emergency Basis:

A patient to be admitted on an emergency basis will be given the opportunity to select a member of the active staff to be responsible for the patient while in the Hospital. If a dentist or podiatrist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient. Where no selection is made or where the selected practitioner does not assume responsibility for care of the patient for some reason, the patient shall be assigned to the on-call physician.

A.8. Transfer of Patients Within the Hospital:

The patient shall not be transferred within the hospital without the approval of the attending physician. The order of priority for patient transfers shall be as follows:

- (a) Emergency Department to appropriate nursing unit;
- (b) From general care unit or Emergency Department to intensive care unit;
- (c) From intensive care to general care unit; or
- (d) From temporary placement in an appropriate nursing unit or clinical service to the appropriate service or nursing unit for the patient being transferred.

A.9. Admission/Discharge to Intensive Care Unit:

Admissions and discharges to the Intensive Care Unit shall be in accordance with established criteria. Exceptions shall be approved by the unit or Service Medical Director or Medicine/Special Care Committee. Only a physician can make the decision to admit or transfer a patient in and out of the Intensive Care Unit. Patients admitted to Intensive Care Unit shall be evaluated by the attending or consultant physician in a timely manner rendering an opinion and recommendation for further care, and must document an opinion in the patient's medical record within twelve (12) hours. Allied Health Professionals may function as additional "eyes and ears" for the physician but they should not act independently. Allied Health Practitioners should not give verbal orders or write orders in the critical care setting unless in consultation with the supervising physician who should document agreement of the order in the progress notes.

A.10) Suspected Suicidal Intent:

Whenever a patient might be a source of danger to himself or others for any cause whatever, the admitting physician shall be responsible for giving such information as may be necessary for hospital personnel to assure the protection of the patient and others. In the event of the admission of a patient with known or suspected suicidal intent, the admitting physician shall advise the patient to seek psychiatric consultation, shall offer assistance in the arrangement for such consultation, and shall document this in the patient's chart.

A.11 Compliance with Utilization Management Plan:

Medical Staff shall abide by the Hospital's Utilization Management Plan to include:

- (a) The appropriateness and medical necessity of admissions;
- (b) Continued stay;
- (c) Supportive services;
- (d) Discharge planning.

A.12 Patient Discharge

Patients shall be discharged only on a written order of the attending physician or his designee. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient should be requested to sign the hospital's "Informed Refusal" form.

A.13 Pronouncement of Death:

In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. In the case of brain death, determination of death shall be made in accordance with currently accepted reasonable medical standards by two (2) members of the Medical Staff. One (1) physician shall be the treating physician, and the other shall be eligible to take the boards in neurology, internal medicine, pediatrics, general surgery or anesthesiology or a board certified neurologist, internist, pediatrician, surgeon or anesthesiologist. The body shall not be released until an entry has been made and signed in the medical record of the deceased by the attending practitioner or his designee of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased shall conform to Florida Statute.

A.14 Autopsies:

The hospital shall attempt to secure meaningful autopsies in accordance with Hospital policy and shall inform the attending physician of the intended autopsy. Unless otherwise provided by Florida law, an autopsy may be performed only with written consent in accordance with Florida law. All autopsies shall be performed by the Hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within seventy-two (72) hours, and the complete protocol should be made a part of the record within sixty (60) days.

B. HEALTH INFORMATION MANAGEMENT (MEDICAL RECORD)

B.1. Responsibility for Preparation of Complete, Legible Medical Record:

The attending physician will be responsible for the preparation and completion of a medical record for each patient. He is responsible only for those parts over which he has control. Its contents shall be pertinent and current for each patient and shall include:

- (a) Identification data;
 - (b) Chief complaint;
 - (c) Medical history;
 - (d) Family history and history of the present illness;
 - (e) Physical examination;
 - (f) Diagnostic and therapeutic orders;
 - (g) Appropriate informed consents;
 - (h) Clinical observations, including results of therapy, progress notes, consultations, comments on laboratory and x-ray and other reports;
 - (i) Provisional and final diagnosis;
 - (j) Medical or surgical treatment;
 - (k) Pathologic findings;
 - (l) Reports of procedures, tests and results, including operative reports;
 - (m) Discharge summary, condition on discharge and instructions given for further care, such as medications, diet or limitations of activity; and
 - (n) Autopsy report, if one is performed.
-
- (1) Orders may be written by the primary physician, his physician designee and any physician consulted by the primary physician.
 - (2) Physician Assistants, Nurse Practitioners, and Nurse Anesthetists may write orders in the chart within the scope of their list of approved privileges and *Florida Statutes*.
 - (3) Supervising physician shall countersign orders in (2) above within twenty-four (24) hours, (twelve (12) hours in Intensive Care Unit).

B.2. Recording History and Physical:

A complete admission history and physical examination shall be recorded within twenty-four (24) hours of admission, including outpatient surgery and observation status. An appropriate medical history and physical examination shall be recorded on all patients prior to undergoing inpatient or outpatient surgery or other high-risk procedure. This report should include all pertinent findings resulting from an assessment of appropriate systems of the body. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission to the Hospital or date of surgical procedure, a legible copy of this record may be used in the patient's medical record providing the history and physical was performed by a Lake City Medical Center Practitioner. In such instances, an interim admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded within the first twenty-four (24) hours of admission. If there are no changes, a note must be entered stating "No Changes", dated and signed within 24 hours of admission but prior to surgery or a procedure requiring anesthesia services.

B.3. Content of History and Physical:

The history and physical shall include: chief complaint, present illness, past medical history (allergies, medications, prior illnesses, and prior surgeries), review of systems, social history, family history and a complete physical exam including specific exam and description of all positive responses in the history.

B.4. History and Physical Not Recorded Before Surgical/Invasive Procedure:

When the history and physical examination is not recorded, either dictated or handwritten, before a surgical or invasive diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states that such delay would be life threatening to the patient.

- (a) If the history and physical has been dictated but not transcribed, there must be a statement to that effect in the patient's chart with an admission note by the physician covering pertinent clinical information.
- (b) In the case of patients undergoing invasive procedures other than in the operating room, a pre-procedural assessment would minimally include, but not be limited to, pertinent historical information such as patient's chief complaint or diagnosis, indication for the invasive procedure, allergies, and current medications. Pertinent physical findings would be noted, the assessment would be appropriate for the procedure performed, and the patient's informed consent shall be documented in the patient's record.

B.5. Progress Notes:

Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as the results of tests and treatments, including physical therapy and respiratory therapy.

- (a) Progress notes shall be written daily on all patients.
- (b) Progress notes written by Allied Health Professionals (Advanced Mid-Level Practitioners and Dependent Practitioners) must be reviewed, amended and countersigned by the supervising physician by the following day.
- (c) Physicians shall enter a formal transfer order in the patient chart when the transfer of a patient is accomplished. The transferring physician shall speak directly to the accepting physician. When a physician accepts care for a patient this acceptance must be recorded in the progress notes.

B.6. Post-Procedural Note/Operative Reports:

A dictated or handwritten Operative or other high-risk procedure reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports or other high-risk procedure report shall be recorded immediately following surgery when possible for outpatients as well as inpatients and the report promptly authenticated by the surgeon and made a part of the patient's current medical record, as soon as possible after surgery, or high risk procedure and before the patient is transferred to the next level of care. Operative Report shall include:

- (a) Surgeon
- (b) Surgical Assistant
- (c) Pre and post-operative diagnosis
- (d) Type of anesthesia
- (e) Procedure (name of procedure performed and description of procedure)
- (f) Specimen removed
- (g) Estimated blood loss
- (h) Post-operative condition
- (i) Findings

If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

B.7. Clinical Entries in the Medical Record:

All clinical entries in the patient's medical record shall be accurately dated, timed and signed. All clinical entries in the physicians' progress notes shall be made only by the attending physician, his physician designee, a consultant, his physician assistant, or the nurse practitioner.

B.8. Consultations:

Request(s) for consultation from a member of the Active Medical Staff must be answered in a timely manner rendering an opinion and recommendation for further care, and must document an opinion in the patient's medical record within 24 hours.

Consultations should include a review of the patient's record by the consultant, pertinent findings on examination of the patient and the consultant's opinion and recommendations. Allied Health Professionals may function as additional "eyes and ears" for the physician but they should not act independently. Allied Health Practitioners should not give verbal orders or write orders unless in consultation with the supervising physician who should document agreement of the order in the progress notes.

- (a) The consultant's plans for follow-up shall be clearly documented with the initial consultation. This report shall be made a part of the patient's record.
- (b) When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.
- (c) The consultant shall specifically sign off the case at the time deemed appropriate.

Any qualified practitioner with clinical privileges in this Hospital can be called for consultation.

B.9. Recording Diagnosis:

The principal diagnosis shall be recorded in full, and dated, timed and signed by the responsible Practitioner at the time of discharge of each patient. This will be deemed equally as important as the actual discharge order.

- (a) When cancer has been newly diagnosed, the appropriate stage shall be specified, if possible, and if the staging workup is complete.

B.10. The Query Form:

The documentation of the inpatient or outpatient coder's query to the physician with the physician's response will be included as a permanent part of the medical record unless an addendum is included to resolve the diagnosis in question.

B.11. Completion of Medical Record

The attending physician shall complete the medical record at the time of the patient's discharge, including progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the medical record will be available in the Medical Records Department. If the discharge summary cannot be dictated at the time of discharge, a final progress note must be written in the medical record.

- B.12. Final Diagnosis:
Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated, timed and signed by the responsible practitioner at the time of discharge of all patients.
- B.13. Discharge Summary:
A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours or a death. The discharge summary should include the final diagnosis, reason for hospitalization, significant findings, procedures performed and treatment rendered, patient condition at discharge, and instruction to the patient and family. For patient stay under forty-eight (48) hours, the final progress notes may serve as the discharge summary and must contain a final diagnosis, outcome of hospitalization, the case disposition and any provisions for follow-up care. All summaries shall be authenticated by the responsible practitioner.
- B.14. Consent of Patient:
Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- B.15. Readmission of Patient:
In case of readmission of a patient, the previous record shall be available upon request for use by the attending practitioner and others involved in the care of the patient.
- B.16. Review of Patient Chart
A physician should not review any patient's chart(s) unless he is involved in the patient's care or has a signed release of information from the patient.
- B.17. Informed Consent:
A medical staff member, his physician designee, or co-admitter shall be responsible for obtaining the patient's informed consent. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital policy. The practitioner shall document that informed consent has been obtained and that the patient understood and agreed to the proposed treatment. The physician will discuss the risks, benefits, and alternatives with the patient/family members and document in the patient's record said discussion.
- B.18. Filing of Medical Record:
A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Resource Management Committee. No staff member may complete a record on a patient unfamiliar to him in order to retire a record of another staff member who is deceased or otherwise permanently unavailable.

B.19. Timely Completion of Medical Record:

The attending practitioner and all physicians involved in the case shall complete their portion of the medical record including the required signatures within thirty (30) days following the patient's discharge.

B.20. Incomplete Medical Record (Delinquency):

A medical record is considered to be delinquent when it has not been completed within thirty (30) calendar days following a patient's discharge. When a Medical Staff member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically relinquished. The relinquishment shall continue until all of the individual's delinquent records are completed.

B.21. Abbreviations:

The Hospital maintains a list of abbreviations, acronyms, and symbols that are unacceptable in patient medical records applicable to all orders and other medication-related documentation when handwritten, entered as free text into a computer, or on pre-printed forms, consistent with the Policy on unacceptable abbreviations (*Abbreviation List: Do Not Use*).

B.22. Allied Health Professional-Patient Assessment:

Allied Health Professionals (Advanced Practitioners) shall be responsible for the preparation of the history and assessment specific to their specialty.

B.23. Access of Information:

(a) Compliance with Information Security Policies:

Each member of the Medical Staff with access to the Hospital medical records agrees to Comply with the Information Security policies of the Hospital set forth in the Information Security Agreement, System Access Authorization and Connectivity Agreement. Such policies include maintaining passwords and Personal Identification Numbers (PIN), which allow access to computer systems and equipment, in strictest confidence and not disclosing passwords and/or PIN with anyone, at any time, for any reason. Each member of the Medical Staff and privileged practitioner understands that the records of the patients maintained are confidential and that access to such records should be limited to those who have a need-to-know in order to provide for care of the patient. Failure to comply with the Information Security policies of the Hospital may result in termination of access to computer systems, paper or other health information records, resulting in the initiation of corrective action as specified in these Bylaws and Policies. Loss of medical staff membership or limitation, reduction, or loss of clinical privileges for any reason may be grounds to terminate access to the system immediately and without notice to the practitioner.

- (b) Access to Records:
Access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee before records can be studied. Subject to the discretion of the Chief of Staff, with the agreement of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
- (c) Access to Previous Records:
Each member of the Medical Staff shall have access to previous hospital records of patients he is attending on an outpatient basis, when affiliation with the patient is evidenced by documentation of previous hospital care. Patient consent must be obtained by a requesting physician, when affiliation is not evidenced in previous healthcare records. At the time of readmission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible at the time of and for the duration of the readmission.
- (d) Unauthorized Release of Information:
Unauthorized release of information from hospital records is grounds for disciplinary action. Unauthorized release includes printing of documents and re-release of these documents to others who do not have appropriate access.
- (e) Hospital Property:
All radiology films, pathology specimens, microscopic slides, photographs, videotapes, photographic slides and medical records are the property of the Hospital. Under no circumstances may any of these items be removed for legal purposes without prior approval of the Chief Executive Officer. Records may be removed from the hospital only in accordance with a court order, subpoena, or statute, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. Unauthorized removal from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

C. GENERAL CONDUCT OF CARE

C.1. Orders

All orders for treatment shall be in writing.

- (a) A verbal order or telephone order shall be considered to be in writing if given to a duly authorized person. These include registered nurse, licensed practical nurse, respiratory therapist, pharmacist, physical therapist, occupational therapist, speech therapist. All verbal/telephone orders shall be “read-back” to the physician once transcribed and then authenticated.
- (b) Telephone orders may be tape recorded to be used for validation of verbal orders. Following transcription of the orders, the individual transcribing the orders will call the physician and read back the orders as written. The individual physician’s permission will be obtained on appointment to the Medical Staff for said taped recordings.
- (c) Only registered nurses, pharmacists, and other authorized licensed personnel may receive medication orders.
- (d) Orders for consultation must include specific reason for consultation. If there is an urgency for a consultant to evaluate a patient, the attending physician must contact that consultant and discuss the case with the consultant directly.

C.2. General Consent Form:

A general consent form, signed by or on behalf of every patient admitted to the hospital, shall be obtained at the time of admission. The admitting office shall notify the appropriate nursing staff when ever such consent has not been obtained. The attending physician shall make an entry in the medical record explaining the reason the consent was not obtainable. Blood administration consent will be in accordance with Hospital Policy.

Surgical/Invasive Procedure Consent:

Informed consents, including the risks, benefits, and alternatives, will be discussed with the patient. A signed, informed, consent for invasive procedures or surgical procedures shall be obtained prior to the operative procedure except in those situations deemed an emergency by the attending physician and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient’s medical record.

C.3. Legibility of Orders:

The practitioner’s orders must be written clearly, legibly and completely, dated and timed. Orders which are illegible or improperly written will not be carried out until clarified by the practitioner and understood by the nurse.

C.4. Personalized Orders:

“Personalized Order” sets (written by an individual practitioner for his patients only) may be utilized by a practitioner. “Standing Order” sets (orders going into effect as needed) require approval through Resource Management Committee prior to utilization. All order forms must be signed, dated and timed by the responsible practitioner when utilized. “Instruction Sheets,” which are used for distribution to our patients, shall be reviewed by all effected departments and revised as necessary. They will be instituted only after approval by the Resource Management Committee and the Medical Executive Committee.

C.5. Cancellation of Previous Orders:

All previous orders are canceled when patients go to surgery or are transferred to or from a special care unit. New orders must be written once a patient is accepted to a new unit including “Do Not Resuscitate”.

In the case of irreversible illness of a patient in which death is imminent where emergency procedures to treat cardiac or pulmonary arrest may not be desired, the physician, after appropriate consultation with the patient and/or family and after adequate documentation in the chart, shall write the order “Do Not Resuscitate”. Specific guidelines for this order are contained within the appropriate Hospital policies and procedures.

C.6. Medication Orders:

All drugs and medications administered to patients shall be those listed in the latest edition of the LCMC Formulary, United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. The use of medications shall be monitored by the Pharmacy and Therapeutics Committee.

Medication orders must be initiated by the physician and shall consist of the drug name, dosage, route and frequency. Orders which do not contain all these elements cannot be carried out until completed by the physician. *See Pharmacy Policy “Responsibility for Medication Ordering” 712.033.*

C.7. Certain Schedule II Controlled Substances:

Certain Schedule II controlled substances carry an automatic ninety-six (96) hour stop order as delineated in the Hospital Stop Order Policy. When the practitioner desires to continue these medications, he must reorder them at the end of this period. The attending practitioner or his designee shall be notified by the responsible nurse when drugs are due for an automatic stop order.

C.8. Medication Administration

Certain medications may be administered only by a physician or under his direct supervision when given by the IV push method. These medications include those in which no FDA approval is available.

In the Radiology Department, Radiologic Technologists may administer contrast media and radioactive materials by the IV push method under the direction of one of the Radiologist.

**Rules & Regulations
May 15, 2007**

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- C.9. Surrender of Medications:
Drugs brought into the Hospital by patients shall be returned home by the patient's family or stored until the discharge of the patient and subject to orders for their continued use by the attending physician. All medications used during hospitalization shall be furnished by the pharmacy unless specific orders to the contrary are written by the attending physician.
- C.10. Ordering Blood:
Blood that has been cross-matched will not be held for any longer than three (3) days unless reordered by the physician. *See policies: "Blood Transfusion" Policy #600.105 and policy "Blood and Blood Component Usage Evaluation and Performance" Policy # HW.013.*
Blood administration consent will be in accordance with Hospital Policy.
- C.11. Consultation Requirements:
Any practitioner with clinical privileges in this Hospital can be called for consultation.
- C.12. Attending Physician Responsibilities-Transfer of Patients:
The attending practitioner or his designee is responsible for transferring patients to the care of another practitioner, or service, at the Hospital. Whenever these responsibilities are transferred to another practitioner, an order for the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made, and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood.
- C.13. Alternate Physician Coverage:
Each appointee of the staff shall designate (sign out to) another appointee of the staff as an alternate to be called to attend his patients when the attending practitioner is not available, or until the attending practitioner can be present. If the alternate physician is not available in a reasonable period of time (not greater than thirty (30) minutes), the Chief of the Department shall be called.

In the case of a medical emergency, the attending physician or his alternate physician shall be called. In case the attending or his alternate is not immediately available, based on the urgency of the situation the Emergency Department physician shall be called and shall have the authority to treat and/or call the on-call practitioner or any other appointee of the staff to attend the patient.

- C.14. Conflict Resolution:
When conflicts occur in the patient care setting that cannot be resolved between hospital staff and members of the Medical Staff, the staff member will notify the Patient Care Coordinator, Supervisor and/or Department Director or the Administrator On-Call of the issue. The Administrator On-Call will notify the Chief of Service when a solution to a physician related issue cannot be reached. The Chief of Service, will attempt resolution and if unable to do so will contact the Chief of Medical Staff. When the conflict can not be resolved at this level the Chief of Medical Staff and the Chief Executive Officer or designee will collaboratively resolve the issue. If at any time the patient's condition warrants immediate medical intervention, the attending physician, Emergency Department physician or Code Blue Policy will be implemented as appropriate.
- C.15. Requests for Radiology and Nuclear Medicine Service:
All requests for radiology and nuclear medicine service must include information from the requesting practitioner justifying the need for the examination(s) requested.
- C.16. Sedation Analgesia:
Sedation analgesia for patients not administered by anesthesiologist must follow "Sedation Analgesia" policy.
- C.17. Restraints:
All forms of physical restraint (including but not limited to, pousy vests, soft wrist, ankle, leather restraints and full side rails) require the following:
- (a) Written order by the physician specifying time duration (not to exceed 24 hours), method and reason for restraint;
 - (b) Orders may not be written as PRN, they are for specific episode and specify start and stop times. *Hospital policy on Restraints shall be followed.*
- C.18. Advance Directives:
All patients are asked whether they wish to implement an advance directive upon admission to the Hospital. Advance directives shall be followed in accordance with Florida law and Hospital policy.
- C.19. Smoking:
Smoking is not permitted anywhere in the hospital building.

C.20. Privacy Practices:

Each member of the Medical Staff, as well as every Practitioner or Allied Health professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to as the “Provider” in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital (unless they opt out), which is defined in 45 C.F.R. §164.501, (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider’s office for purposes of the Provider’s payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital’s registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

C.21. Withholding or Withdrawing Life Support:

Each member of the staff will abide by the guidelines set forth in the Hospital policy concerning the withholding or withdrawing life prolonging procedure.

D. EMERGENCY DEPARTMENT SERVICES

- D.1. Emergency Service Call Responsibility:
Appointees of the active and provisional active Medical Staff shall accept responsibility for Emergency Department call coverage and be available to the Hospital to respond in a timely manner as designated in the Qualifications of Membership Grid.
- D.2. Delineation of Clinical Privileges – Practitioners Rendering Emergency Care:
Clinical privileges shall be delineated for all Medical Staff members rendering emergency care in accordance with Staff and Hospital procedures. Treatment and performance of operative and other procedures shall be provided within those areas of competence indicated by the scope for the practitioner’s delineated clinical privileges.
- D.3. Responsibility for Emergency Department:
The Physician Director of the Emergency Department or the Medicine/Special Care Committee shall have the oversight responsibility for the quality of care within the Emergency Department.
- D.4. Emergency Department Coverage:
(a) Emergency Department physician rosters are prepared by the contracted emergency service and posted in the Emergency Department.
(b) Medical and Surgical rosters will be prepared by the Medical Staff and are posted in the Emergency Department.
- D.5. Availability of Emergency Department Physician:
An Emergency Department physician shall be in the hospital and immediately available for rendering emergency patient care twenty-four (24) hours per day, seven (7) days per week.
- D.6. Medical Screening Exam:
All patients presenting to the Emergency Department regardless of the point of entry will receive a medical screening exam to determine if an “Emergency Medical Condition” exists. This will be done without delay to inquire about insurance status or ability to pay.
- D.7. Medical Screening Process:
The medical screening process is two-tiered. Triage personnel perform an initial examination in accordance with the protocols listed in the triage manual. The triage examination may be performed by the Emergency Department physician, the patient’s private physician (if they intend to provide the medical screening exam in the emergency), physician assistant, advanced registered nurse practitioner, or registered nurse with the expertise to determine the extent and nature of the emergency. Emergency Department triage personnel are responsible for determining the order in which emergency department patients receive the screening examination.

The medical screening examination may be performed by the Emergency Department physician, the patient's private physician, physician assistant, or advanced registered nurse practitioner.

D.8. Screening of Individuals Who Present to Hospital:

In general, when an individual comes by him or herself or with another person and is not technically in the Emergency Department, but on Lake City Medical Center hospital property, or owned or operated by Lake City Medical Center premises, (MRI, Rehabilitation Services, Sleep Lab, Seniors United, Annex, Cath Lab) and requests emergency care, the Hospital staff will

- (a) Call 911 and then
- (b) Provide whatever assistance available while awaiting arrival of EMS personnel;
- (c) Personnel in the department will contact the dedicated emergency department and speak to the Charge Nurse.
 - (1) Describe the patient's appearance
 - (2) Report all symptoms
 - (3) Report any care provided
- (d) EMS will transport the patient to the Emergency Department;
- (e) If a patient presents to a department within the hospital other than the dedicated Emergency Department asking for emergency medical treatment the staff will escort the patient to the Emergency Department.

D.9. Admission of Emergency Department Patient:

If a patient needs to be admitted to the Hospital as an inpatient, based on the judgment of the Emergency Department physician, either for observation or for further treatment, the patient shall be admitted in the name of the patient's practitioner or the practitioner on-call.

- (a) All patients shall be admitted, with orders from the attending practitioner (or designee).
- (b) Emergency Department physicians may not write admitting orders except as granted by the Executive Committee.
- (c) If the patient is to be evaluated by the attending physician in the Emergency Department the attending physician will be required to appear in the Department within a reasonable time to complete the evaluation. If the Department situation will not allow a patient to be held, the attending physician will be informed and the Emergency Department physician will evaluate the patient.

- (d) The transfer of responsibility for the care of the patient from the Emergency Department physician to the attending physician shall occur at the time that the patient is transferred to the Nursing Unit. (Exception: when extenuating circumstances exist and a patient is required to remain in the Emergency Department awaiting an available bed, the transfer of responsibility shall occur when orders are received from the attending physician, or after the patient has been examined in the Emergency Department by the attending physician.)

D.10. Emergency Department Medical Record:

An appropriate Emergency Department medical record shall be kept for every patient receiving emergency treatment and shall be incorporated in the patient's previous inpatient medical record, if such exists. All records of patients shall be kept in Medical Records Department under a unit record system. The Emergency Department medical record shall include:

- (a) Adequate patient identification;
- (b) Information concerning the time of the patient's arrival and by whom transported;
- (c) Pertinent history of the injury or illness, including details relative to first aid emergency care given the patient prior to his/her arrival at the Hospital, history of allergies and list of medications;
- (d) Description of significant clinical, laboratory and x-ray findings;
- (e) Diagnosis, including condition of patient;
- (f) Treatment given and plans for management;
- (g) Condition of the patient on discharge or transfer; and
- (h) Final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow-up care.

D.11. Signing of Emergency Department Records:

Each patient's Emergency Department record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

D.12. Medical Record Upon Admission:

A copy of the Emergency Department medical record shall accompany patients being admitted as an inpatient.

D.13. Transfer of Patients:

Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility when, in the judgment of the attending physician, the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.

D.14. Responsibility for Studies:

The Emergency Department Physician Director, when requested, shall be responsible for review of emergency service records or studies concerning the quality and appropriateness of patient care and report results to the appropriate Medical Staff Committee.

- D.15. Disaster Plan:
The Emergency Department Medical Director shall make certain that Emergency Department procedures are properly coordinated with the Hospital's Emergency Management Plan, especially as they pertain to the care of mass casualties.
- D.16. Compliance with Florida Statutes:
Emergency Department policies and procedures shall at all times conform to requirements of *Florida Statutes*.
- D.17. Pediatric Admission:
Lake City Medical Center defines Pediatric patients as under 12 years of age. No patient under 12 years of age will be admitted as an inpatient.

E. SURGICAL SERVICES

E.1. Requirements Prior to Surgery:

Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultation, when requested, must be recorded on the patient's medical records prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery) and that the patient's condition is deemed to be satisfactory for the planned surgery.

In all other cases the responsible nurse shall notify the operating surgeon, preferably no later than the night before surgery is scheduled, and preparation for surgery including premedication shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

E.2. Pre-Surgical Clearance:

An appropriate specialist must evaluate any system(s) in question to assure the patient can tolerate the anesthesia and operative procedure scheduled. A statement by this specialist shall be made in the medical record with any additional recommendations prior to the operative procedure. It shall be the responsibility of the Operating Surgeon to see that such clearance has been completed prior to surgery.

The attending practitioner, the operating surgeon, or a designee shall have documented on the chart an H&P with specific reference to examination of the heart, lungs, and area of concern prompting the surgical procedure. Appropriate lab studies shall also be documented prior to surgery.

E.3. Timeliness of Physician Presence in the Operating Room:

Surgeons shall be in the operating room and ready to commence surgery at the time scheduled.

If a surgeon is repeatedly or flagrantly late, he may have his privilege to schedule first case surgery suspended or may be referred to the Medical Executive Committee for action.

The primary surgeon or assistant surgeon shall remain in attendance with the patient from the time the operation is started until closure. A physician may not be primary surgeon on simultaneous cases.

E.4. Anesthesiologist Responsibilities:

The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesia record should also include thorough documentation of times and amounts of all medications given.

- (a) A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services. The anesthesiologist is responsible for writing a pre-anesthetic assessment in the medical record prior to the patient's transfer to the operating area and immediately before pre-operative medication has been administered. This assessment shall indicate a choice of anesthesia and the surgical procedure anticipated.
- (b) A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. The anesthesiologist is responsible for writing a post-anesthetic assessment on admission to and discharge from post-anesthesia recovery care to include at least a description of the presence or absence of anesthesia-related complications.

E.5. Preceptors:

A staff appointee who is classified in a preceptorship or supervisory status for specified surgery privileges must have present his preceptor or supervising physician for these specified surgery procedures.

E.6. Care of Dental Patients:

A patient admitted for dental care is a dual responsibility of the dentist and co-admitting Medical Staff physician.

- (a) Dentist's responsibilities:
 - (1) A detailed dental history justifying hospital admission;
 - (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis;
 - (3) A complete operative report, describing the findings and techniques. In cases of extraction for teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination;
 - (4) The dentist is totally responsible for the oral or dental care;
 - (5) Progress notes as are pertinent to the oral condition;
 - (6) The discharge order; and
 - (7) Discharge summary pertinent to the dentistry aspect of care.

- (b) Physician's responsibilities:
 - * (1) Medical history pertinent to the patient's general health;
 - * (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;
 - (3) Supervision of the patient's general health status while hospitalized;
 - (4) Physician is not responsible for any dental care or consequences thereof; and
 - (5) Medical discharge summary.

*May be performed by a qualified oral surgeon if they have such privileges in order to assess the medical, surgical, and anesthesia risks of the proposed operative and other procedure(s).

E.7. Care of Podiatric Patient:

A patient admitted for podiatry care is a dual responsibility involving the podiatrist and Co-admitting Medical Staff physician.

- (a) Podiatrist's responsibilities:
 - (1) A detailed history justifying hospital admission;
 - (2) A detailed description for the examination of the feet and pre-operative diagnosis;
 - (3) A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination;
 - (4) Progress notes;
 - (5) The podiatrist is solely responsible for the care of the feet;
 - (6) The discharge order; and
 - (7) Discharge summary (or summary statement) pertinent to the podiatric aspect of care.
- (b) Physician's responsibilities:
 - (1) Medical history pertinent to the patient's general health;
 - (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;
 - (3) Supervision of the patient's general health status while hospitalized;
 - (4) Physician is not responsible for any podiatric care or treatment of feet or consequences thereof; and
 - (5) Medical discharge summary.

E.8. Surgical Procedures Performed by Dentists and Podiatrists:

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery.

E.9. Disposition of Specimens/Tissues:

Unless otherwise specified by Hospital policy, all tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

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May 15, 2007**

Revised: November 18, 2008; August 13, 2009; November 17, 2009; December 14, 2010; March 15, 2011; June 21, 2011

E.10. Scheduling of Elective or Non-Emergency Surgery:

The rules for the scheduling of elective or non-emergency surgery will be as follows:

- (a) The schedule is available for posting of cases at all times;
- (b) The following information is requested in order to post a case:
 - (1) The patient's full name;
 - (2) Date of Birth;
 - (3) Sex;
 - (4) Procedure;
 - (5) Type of anesthesia;
 - (6) Surgeon;
 - (7) Social Security Number or Medical Record Number; and
 - (8) Date, time and name of person posting the case.
- (c) Elective or non-emergent cases will be scheduled on a "first come first serve basis". The scheduling and sequence of cases will be based on available operating room personnel and equipment, room cleaning, and other factors determined by the operating room supervisor.
- (d) Emergency cases can supersede the previously scheduled cases; however, if the surgeon in the previously scheduled case and the surgeon with the apparent emergency case cannot reach an agreement on the sequence of scheduling of the two cases, then the Chief of Surgery, or in his absence the Chief of Staff will make the decision on the order of the cases.

F. INFECTION CONTROL

The Medical Executive Committee shall approve a policy authorizing Infection Control Practitioner to institute, in the absence of an attending physician, any appropriate control measures when there is reason to believe that a condition exists which might prove dangerous to any patient(s) or personnel. The Infection Control Practitioner and Quality Improvement Council shall also be authorized to institute any control studies which it deems necessary.

The Infection Control Practitioner will be annually responsible for the amendments and review of the Infection Control Improvement Plan. The Quality Improvement Council will annually review and approve this Plan.

G. EMERGENCY MANAGEMENT PLAN

There will be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Staff and the Board of Trustees.

G.1. The disaster plan should make provision within the hospital for:

- (a) Availability of basic utilities and supplies, including water, food and essential medical and supportive materials;
- (b) A system of notifying and assigning personnel;
- (c) Administration will coordinate with Chief of Staff or his designated substitute for physician resources;
- (d) Conversion of all usable space into clearly defined areas for triage, for patient observation and for immediate care;
- (e) Prompt transfer, when necessary, after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;
- (f) A special disaster medical record, such as an appropriately designated tag, that accompanies the casualty as he is moved;
- (g) Procedures for the prompt identification of discharge or transfer of patients in the Hospital who can be moved without jeopardy;
- (h) Maintaining security in order to keep relatives and curious persons out of the triage areas; and
- (i) Pre-establishment of a public information center and assignment of public relations liaison duties.

All Medical Staff members may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of the Medical Staff of the Hospital and the CEO will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of the Medical Staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief of the Medical Staff and the CEO of the Hospital. In their absence, the Vice President of the Medical Staff and alternate in administration are next in line in authority, respectively.

**Rules & Regulations
May 15, 2007**

Revised: November 18, 2008; August 13, 2009; November 17, 2009; December 14, 2010; March 15, 2011; June 21, 2011

The disaster plan shall be rehearsed in accordance with JCAHO requirements, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made and forwarded to the Environment of Care Committee for evaluation and feedback.

H. MISCELLANEOUS

H.1. Utilization Management, Quality Assessment and Performance Improvement Plans:
The Utilization Management, Quality Assessment and Performance Improvement Plans of this hospital, as approved by the Medical Executive Committee, Medical Staff, and the Board of Trustees, shall be adhered to by all Medical Staff members.

H.2. Policies and Procedures:
Policies and Procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Staff and approved by the Medical Executive Committee and the Board of Trustees, if applicable, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of all current directives.

H.3. Location of Policies and Procedures:
Policies and Procedures referred to above and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedure Manual of the Hospital.

H.4. Reporting Sanctions:
All practitioners must report any sanctions they receive inclusive of any sanction from the Peer Review Organization to the CEO and the MEC. Additionally, the Hospital shall verify each practitioner's status as an Ineligible person.

H.5. Patient Care Services Performed Outside the Hospital:
When patient care services which influence or affect the care of patients at Lake City Medical Center are performed outside the hospital by individual(s) who are not members of the Lake City Medical Staff or other entities; the quality of care of this individual(s) or other entity should be monitored by the Medical Staff and meet applicable standards. If results are below the accepted quality of care standards, the appropriate governmental organization shall be notified.

I. AMENDMENTS

These Rules and Regulations may be amended as delineated in Article Twenty-five (25) of the Medical Staff Bylaws.

J. ADOPTION

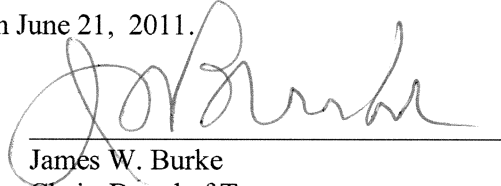
These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Rules and Regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on June 8, 2011.



Alejandro Soler, M.D.
President, Medical Staff

Approved by the Board of Trustees on June 21, 2011.



James W. Burke
Chair, Board of Trustees